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The Ohio State MEDICAL JOURNAL

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NUMBER 1

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FEB 1075

RECD		GRUGLERS	
Original Articles		Keeping Up	
Sequel Technique for Localization and Extraction of Radiopaque Foreign Bodies in Various Ana- tomic Sites. William G. Meyer, M.D., Co- lumbus	15	Continuing Education Courses for Physicians Scheduled Throughout Ohio	4
Nonspecific Recurrent Jejunal Ulceration. William P. Skivolocki, M.D., Ph.D.; Kenneth Sirinek, M.D.; and Thomas Brewer, M.D., Columbus Effect of Water Fluoridation on Urinary Tract Calculi. Jack L. Summers, M.D., and Walter A. Keitzer, M.D., Akron Editor's Note: Policy of the AMA Reference Fluoridation of Public Water Supplies	18 25 27	Public Health Zoster Immune Globulin Program	8
		Woman's Auxiliary	
Your AMA at Work		A New Emphasis—Communications	51
AMA Approves Definition of Family Physician Report on American Medical Association Clinical Convention in Portland on December 1-4, 1974 Statement of the American Medical Association Before the U.S. House of Representatives Sub-Committee on Rural Development AMA House of Delegates Policy on "Service versus Medical Education"	28 38 44 25	Other Features A Half Century of Health Progress. Harry Schwartz, Ph.D. New Members Obituaries Who Contributes to the Malpractice Crisis? Richard L. Meiling, M.D.	58 49 60 41
Your Stake in Federal Health Manpower Legislation, Health Power Planning, and Resource Development Legislation	29 42 61	The Journal The Journal's Advertisers in This Issue Classified Advertisements	62 63
Annual Meeting Information48, 30,	0.1	Chassifica Auvertiscinents	00

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REC'D

CIRCULAILS



- Predominant psychoneurotic anxiety
- Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor

neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive dis-

orders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime. Valium can offer an additional benefit. An h.s. dose added to the b.i.d. or t.i.d. treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



2-mg, 5-mg, 10-mg tablets

in psychoneurotic anxiety states with associated depressive symptoms

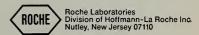
surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies.

Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle

spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.





VOL. 71

JANUARY, 1975

NO. I

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MEALTH SCIENCES LIBRARY UNIVERSITY OF MARYLAND BALTIMORE

Offer Exam On Chest Disease To Test Your Knowledge

A Self-Assessment Examination in Chest Disease has been developed by the American College of Chest Physicians. Available to all physicians, the test is the result of two years of concentrated work, study and revision by a committee of physicians representing the major disciplines of chest medicine.

Field tested in Toronto during the College's annual meeting, the examination's goal is to present common clinical problems which require evaluation and treatment. All clinical material in the examination is from actual patients of committee members. Accredited for up to 22 hours of credit toward American Medical Association's Physician Recognition Award in Category 5-D, the examination is credited for each hour spent working with the test. Those physicians who completed the entire examination during its field test at the annual meeting did so in four to six hours.

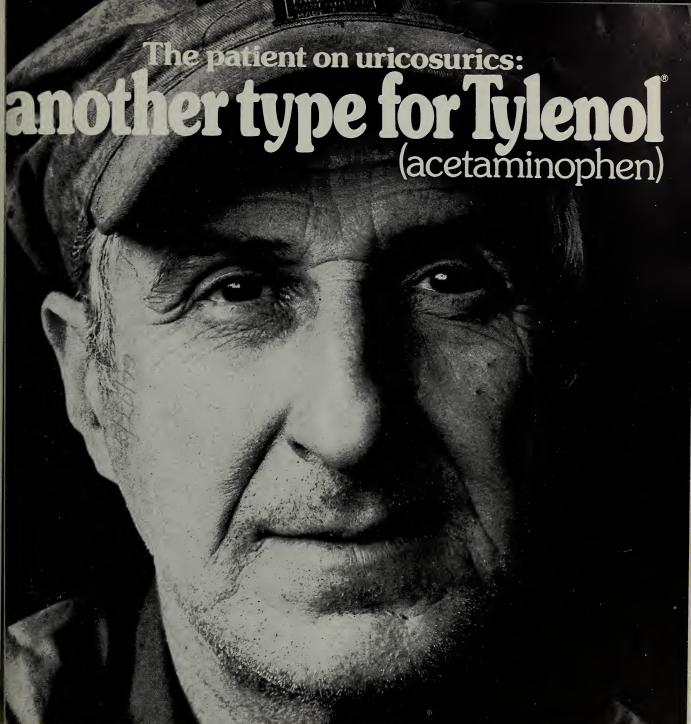
Physicians ordering the examination will be sent a test booklet containing case material and questions, a response booklet and return envelope. After completing the examination, the physician will return his answer booklet for computer grading. His booklet will be returned to him, accompanied by an answer key, a set of discussions and a bibliography keyed to each test case. Scores will be held in strict confidence.

To obtain the test, send requests to the American College of Chest Physicians, P.O. Box 93826, Chicago, Ill., 60690, with a check made payable to the ACCP. Participation fees are \$35 for ACCP members, \$40 for non-member physicians and \$25 for residents.

The American Academy of Family Physicians is sponsoring a project aimed at educating the public in preventive health care. A Compendium of Patient Education Materials is scheduled for use this month.

Designed for dissemination by the doctor to his patients, the compendium covers a broad spectrum of health-related subjects attractively presented in layman's language for easy assimilation. Approximately 280 subjects on health, safety and quality of life are covered in the new publication. This compendium, which can save physicians time on patient education, is available for a very nominal sum. Physicians interested in obtaining a copy (or copies) should contact the Communications Division, American Academy of Family Physicians, 1740 W. 92nd St., Kansas City, Mo. 64114.

" Poline Contents



When the patient on uricosuric therapy requires an analgesic, a new problem arises. Aspirin in the usual analgesic doses inhibits the action of uricosurics.^{1,2}

TYLENOL (acetaminophen), on the other hand, causes no appreciable uricosuric antagonism² and for this reason is preferred over aspirin in the gout patient.

This is only one of several types for TYLENOL'—that is, patients who should avoid aspirin. Considering all of them, wouldn't it provide added safety (as well as added convenience) to recommend TYLENOL (acetaminophen) routinely for simple analgesia?

References: 1. Martin, E.W., et al., ed.: Hazards of Medication, Philadelphia, J.B. Lippincott Co., 1971, p. 511. 2. Seegmiller, J.E.: Med. Clin. North Amer. 45:1259-1272 (Sept.) 1961.

Precautions and Adverse Reactions: If a rare sensitivity reaction occurs, the drug should be stopped. TYLENOL (acetaminophen) has rarely been found to produce any side effects.

Supplied: Tablets, 325 mg. For Children: Elixir, 120 mg./5cc. (alcohol 7%). Drops, 60 mg./0.6cc. (alcohol 7%). Chewable Tablets, 120 mg.

Safer than aspirin, yet just as effective for relief of pain and fever

Tylenol (acetaminophen)

McNEIL McNeil Laboratories, Inc., Fort Washington, Pa. 19034

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Continuing Education Opportunities for Physicians in Ohio

January

Family Medical Review — Sponsored by Ohio Academy of Family Physicians, 4075 N. High St., Columbus 43214; Imperial House North, Columbus; Jan. 25-26.

Gastroenterology — Sponsored by OSU College of Medicine Center for Continuing Medical Education; 320 W. Tenth St., Columbus 43210; Meeting at Fawcett Center for Tomorrow, 2400 Olentangy River Road, Columbus; Jan. 29.

Medical Progress for the Family Physician — Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; Cosponsor, American Academy of Family Practice; Jan. 29-30.

February

Renal Disease Symposium — University of Cincinnati College of Medicine, CONMED, 234 Goodman St., Cincinnati 45229; Feb. 3-7.

Infectious Diseases — OSU College of Medicine, Center for Continuing Medical Education, 320 W. Tenth Ave., Columbus 43210; Meeting at Fawcett Center for Tomorrow, 2400 Olentangy River Road, Columbus; Feb. 5.

Sports Medicine — Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; Feb. 5-6.

Pressure in Anesthesiology — Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; Feb. 7-9.

Pediatric Workshop — Ohio Academy of Family Physicians, 4075 N. High St., Columbus 43214; cosponsored by Indiana Academy of Family Physicians; at Hueston Woods Lodge, College Corner, Ohio; Feb. 8-10.

Selection of Antibiotics for Use in Infants and Children — Steubenville Country Club; Feb. 11 at 8:15 p.m.; speaker will be Henry G. Cramblett, M.D., Columbus; sponsored by the Fort Steuben Academy of Medicine.

Pathology Seminar — OSU College of Medicine, Center for Continuing Medical Education, 320 W. Tenth Ave., Columbus 43210; February 12; fee is \$40.

Children, Adolescents and the Adult Psychiatrist — Marriott Inn, Cleveland; Feb. 14-16; for further information, contact Ohio Psychiatric Association, 88 East Broad St, Columbus 43215.

Electromyography — OSU College of Medicine Center for Tomorrow, 320 W. Tenth St, Columbus 43210; Feb. 17-20; fee is \$225.

Physicians in Nuclear Medicine — The Nuclear Medicine Institute, Cleveland, will sponsor a 4-week continuing education course for physicians in nuclear medicine; on Feb. 17-21, March 17-21, April 14-18, May 12-16; each session is Monday through Friday; for further information, contact D. Bruce Sodee, M.D., Director, Nuclear Medicine Institute, 6760 Mayfield Rd, Cleveland, 44124.

Electromyography XV — OSU College of Medicine, Center for Continuing Medical Education, 320 W. Tenth Ave., Columbus 43210; February 17-20; fee is \$225.

Management of Ear, Nose, and Throat Disorders — Stouffer's University Inn; sponsored by OSU College of Medicine, Center for Continuing Medical Education, 320 W. Tenth Ave., Columbus 43210; February 19; fee is \$40.

Ear, Nose, Throat Disorders — Sponsored by OSU College of Medicine Center for Continuing Medical Education, 320 W. Tenth Ave., Columbus 43210; Meeting at Stouffer's University Inn., 3025 Olentangy River Road, Columbus; Feb. 19.

Annual Infectious Disease Conference — University of Cincinnati College of Medicine, CON-MED, 234 Goodman St., Cincinnati 45229; Feb. 20.

Orthopaedic Problems - OSU College of Medicine Center for Continuing Medical Education, 320 W. Tenth Ave., Columbus 43210; Meeting at the Fawcett Center for Tomorrow, 2400 Olentangy River Road, Columbus; Feb. 26.

Blood Bank Management — Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; Feb. 26-27.

Orthopaedic Problems — Fawcett Center for Tomorrow, 2400 Olentangy River Rd., Columbus; sponsored by OSU College of Medicine, Center for Continuing Medical Education, 320 W. Tenth Ave., Columbus 43210; February 27; fee is \$40.

March

Opthalmology Symposium — Fawcett Center for Tomorrow, 2400 Olentangy River Rd., Columbus; sponsored by OSU College of Medicine, Center for Continuing Medical Education, 320 W. Tenth Ave., Columbus 43210; March 3-4; fee is \$100.

Common Post-Operative Complications: Prevention and Treatment — Hospitality Motor Inn, Middleburg Heights; sponsored by the Westshore Foundation for Medical Education; 9:00 a.m. to 5 p.m.; March 5.

Some Thoughts on Total Care of Patients with Cancer — Steubenville Country Club; Mar. 11 at 8:15 p.m.; speaker will be Arthur J. Murphy, Jr. M.D., Pittsburgh; sponsored by Fort Steuben Academy of Medicine.

Medical Progress and its Relationship to Dentistry — Cleveland Clinic Educational Foundation, 9500 Euclid Ave, Cleveland 44106; Mar. 12-13; fee is \$45.

Annual VA Hospital Symposium — University of Cincinnati College of Medicine, Office of CONMED, 234 Goodman St, Cincinnati 45229; Mar. 13.

Core Curriculum: Pediatric Echocardiography — Sponsored by the American College of Cardiology, Cincinnati, March 17-20, 1975. For details, contact: American College of Cardiology, Department of Continuing Education Programs, 9650 Rockville Pike, Bethesda, Md. 20014.

Laser Safety Short Course — University of Cincinnati College of Medicine, Office of CONMED, 234 Goodman St, Cincinnati 45229; Mar. 17-21; fee is \$325.

10th Annual Cancer Symposium — Akron City Hospital, Institute of Medical Education; Mar. 19-20; fee is \$10.

Recent Progress in Clinic Cancer — Cleveland Clinic Educational Foundation, 9500 Euclid Ave, Cleveland 44106; Mar. 19-20; fee is \$80.

General Practice Seminar — Fawcett Center for Tomorrow, 2400 Olentangy River Rd, Columbus; Mar. 22-23; fee is \$50; sponsored by OSU College of Medicine Center for Continuing Education.

Care of the Critically Ill Child — Sponsored by The Children's Medical Center and Wright State University School of Medicine; contact: Director of Medical Services, Children's Medical Center, 1735 Chapel Street, Dayton 45404; March 26; fee is \$20.

April

Practical Neurology — Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; April 2-3; fee is \$80.

Lederle Symposium on Arthritis — Sheraton-Columbus Hotel, Columbus; co-sponsored by the Ohio Academy of Family Physicians; April 6.

Use and Abuse of Injectable Steroids — Steubenville Country Club, Annual Trauma Meeting of Fort Steuben Academy of Medicine; Robert J. Murphy, M.D. of Columbus; 8:15 p.m.; April 8.

Refresher Seminar in Pediatrics for Pediatricians — General Practitioners — Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; April 9-10; fee is \$80.

Drug Therapy — Fallsview Mental Health Center, Cuyahoga Falls; sponsored by the Association of Physicians of Ohio; G. Batizy, M.D.; April 11.

Paramedical Workshop — Ramada Inn North, Columbus; sponsored by the Ohio Academy of Family Physicians; April 12-13.

Practical Perimetry for Beginners — Holiday Inn, Columbus; sponsored by the OSU College of Medicine, Center for Continuing Medical Education, 320 W. Tenth Ave., Columbus 43210; April 14-15; fee is \$70.

Diagnostic Immunology — Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland, 44106; April 23-24; fee is \$80.

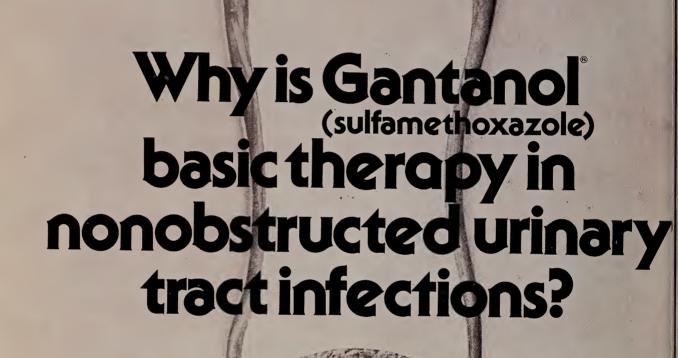
Family Relations Workshop on Family Dynamics — Salt Fork Lodge, Cambridge; sponsored by the Ohio Academy of Family Physicians; April 25-27; fee is \$50 for members and \$65 for nonmembers.

Biomechanics — Cleveland Plaza, Cleveland; sponsored by the American Academy of Orthopaedic Surgeons; April 28-May 2; fee is \$150 for members, \$250 for non-members and \$125 for residents.

Abdominal Surgery — UC Medical Center; contact University of Cincinnati College of Medicine, Office of CONMED, Dean's Office, 234 Goodman St., Cincinnati; April 30-May 1; fee is \$100, \$50 for residents.

May

Microneurosurgery Symposium, Cincinnati Convention Center, May 29-31, 1975. Directors: Stewart B. Dunsker, M.D., and John M. Tew, M.D. Lectures, practical demonstrations and discussions will be provided by an international faculty. Special courses for nurses and surgical assistants also will be conducted. Sponsored by the Departments of Neurosurgery, The Christ and Good Samaritan Hospital, Frank H. Mayfield, M.D., Director. For details, write: Ms. S. Stuckey, Coordinator, Microneurosurgery Symposium, 506 Oak St., Cincinnati 45219.



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute, recurrent or chronic nonobstructed urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms. Note: Carefully coordinate in vitro sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides, especially in chronic or recurrent urinary tract infections. Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

Warnings: Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-hemolytic strep-

tococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom doserelated hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: Blood dyscrasias (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, pur-

Because it is considered a good choice...

- for efficacy in nonobstructed cystitis, pyelonephritis and pyelitis
- for control of susceptible E. coli, Klebsiella-Aerobacter, Staph. aureus, Proteus mirabilis and, less frequently, Proteus vulgaris
- for prompt antibacterial blood and urine levels in from 2 to 3 hours after initial 2-gram adult dose
- for economical around-the-clock coverage
- for maximum patient cooperation with easy-toremember B.I.D. dosage

Basic Therapy Gantanol (sulfamethoxazole)

Tablets/Suspension (0.5 Gm) (0.5 Gm/teasp.)

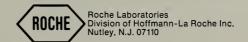
pura, hypoprothrombinemia and methemoglobinemia); allergic reactions (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); gastrointestinal reactions (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); CNS reactions (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); miscellaneous reactions (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis).

Usual adult dosage: 2 Gm (4 tabs or teasp.) initially, then 1 Gm b.i.d. or t.i.d. depending on severity of infection.

Usual child's dosage: 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs b.i.d. Maximum dose should not exceed 75 mg/kg/24 hrs.

Supplied: Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.



Community Health News

Ohio Department of Health

John H. Ackerman, M.D., Deputy Director

ZOSTER IMMUNE GLOBULIN PROGRAM

Zoster Immune Globulin (ZIG) is again available for national distribution through the Center Disease Control's ZIG Program. Unlike previous years when ZIG of a single titer was distributed, ZIG will be distributed from 2 lots of differing titer according to a protocol investigating dose-efficacy relationships. Susceptible children with high-risk conditions (leukemia, lymphoma, immunodeficiency conditions, or treatment with immunosuppressive medications) who have been exposed to a confirmed active case of varicella within the previous 72 hours are eligible for ZIG prophylaxis. In addition, ZIG will be available for

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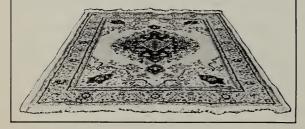
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the first time to neonates at high risk of congenital varicella, i.e. when maternal varicella first appears within 4 days before delivery. Adults, children with already established varicella-zoster infection, and children with previous history of varicella zoster infection are not eligible for ZIG prophylaxis.

Physicians caring for children who have been exposed to varicella and meet the above criteria should contact one of the regional ZIG consultants or the Ohio Department of Health, Division of Communicable Diseases.

Plasma for future lots of ZIG is now being accepted. Untitered plasma is accepted from donors 1 to 5 weeks after onset of herpes zoster or varicella rash. Further information regarding plasma donation to the ZIG Program may be obtained from the Immunization Division, Bureau of State Services, Center for Disease Control.

REGIONAL ZIG CONSULTANTS

Robert L. Rosenberg, M.D.

John F. Modlin, M.D. J. Lyle Conrad, M.D.

Walter A. Orenstein, M.D.

Center for Disease Control, Atlanta 30333

Office: (404) 633-3311, ext. 3736, 3739 Residence: (404) 378-0379 (Dr. Rosenberg)

(404) 325-4319 (Dr. Modlin) (404) 636-3902 (Dr. Conrad)

(404) 633-2727 (Dr. Orenstein)

Richard G. Judelsohn, M.D.

857 Delaware Avenue, Buffalo 14209 Office: (716) 884-8018 or

(716) 634-0744

Residence: (716) 688-5579

TUBERCULOSIS UPDATE

New active cases of tuberculosis continue to decline in number each year in Ohio. Even more encouraging to hopes of eventual eradication is the extremely low rate of skin test positivity in 5-6 year olds, indicating that transmission of the disease has almost been halted in most areas of the State.

(Continued on Page 13)

(Continued)

In the past five years, the Ohio Department of Health Tuberculosis Program has changed emphasis from mass screening and hospitalization to selective screening (primarily of contacts to new active cases), out-patient treatment, hospitalization in general hospitals when hospitalization is required, and isoniazid prophylaxis for those at high risk.

As a result of these changes, there has been increasing involvement of the private practitioner in the management of tuberculosis cases. In our opinion, this has resulted in better over-all medical care, particularly where illnesses concurrent with tuberculosis exist. The duration of hospitalization has decreased considerably. Hospitalization is reserved only for those patients who are acutely ill. Approximately 50 percent of all cases are now being treated entirely as out patients.

Experience in Ohio, as well as other states, has shown no benefit in follow up of patients beyond the period of active treatment (18-24 months). Patients are instructed to report to their physician if symptoms recur.

The new look in tuberculosis control is really a return of the management of the disease to the mainstream of medicine. No longer are patients isolated for long periods of time in special hospitals and treated by special doctors.

These changes have resulted in a great reduction in the cost of tuberculosis management and control programs and improvement in patient cooperation and improvement in over-all medical care for the patient.

John A. Bergfeld, M.D. of Euclid, has been appointed Head of the Section on Sports Medicine of the Cleveland Clinic's Department of Orthopaedic Surgery. Dr. Bergfeld received his M.D. degree at Temple University, School of Medicine in 1964, and took his orthopaedic specialty training at the Cleveland Clinic.

The Clinic's Sports Medicine Section was established in 1969 to conduct research into the mechanisms and prevention of sports injuries and provide treatment and rehabilitation tailored to the particular needs of athletes.

The American College of Sports Medicine has planned its Twenty-Second Annual Meeting for May 22-24 at the Marriott Hotel in New Orleans. As a special feature, a delegation of Soviet scientists will present a symposium on the History and Current Status of Sports Medicine in the Soviet Union.

TREAT THE SYMPTOMS IN THE GERIATRIC PATIENT

APATHY • IRRITABILITY **FORGETFULNESS • CONFUSION**



Cerebro-

A GENTLE CEREBRAL STIMULANT & VASODILATOR FOR GERIATRIC PATIENTS

Each CEREBRO-NICIN capsule contains: Each CEREBRO-NICIN capsule contains:
Pentylenetetrazole ... 100 mg. • Nicotinic Acid ... 100 mg.
Ascorbic Acid ... 100 mg. • Nicotinic Acid ... 25 mg.
I-Glutamic Acid ... 50 mg. • Niacinamide ... 5 mg.
Riboflavin ... 2 mg. • Pyridoxine HCI ... 3 mg.
AVAILABLE: Bottles 100, 500, 1000
SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and abdominal cramps. The reaction is usually transient.
INDICATIONS: As a cerebral stimulant and vasodilator.
RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.
WARNING: Overdosage may cause muscle tremor and con-Overdosage may cause muscle tremor and con-CONTRAINDICATIONS: Epilepsy or low convulsive threshold. CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

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Kefzol[®] cefazolin sodium

Ampoules, equivalent to 1 Gm. of cefazolin





Additional information available to the profession on request. Eli Lilly and Company Indianapolis, Indiana 46206 400380

Sequel Technique for Localization and Extraction of Radiopaque Foreign Bodies in Various Anatomic Sites

William G. Meyer, M.D.

An innovative method for localization and removal of radiopaque foreign bodies using "cutout" radiologic films.

IN SEPTEMBER 1969, this *Journal* published my article entitled "Metallic Foreign Bodies in the Sole of the Foot," which described a new technique for localization and extraction. Abstracts of the article appeared in *Modern Medicine* (vol. 38, no. 22) and in the June 1970 issue of *Emergency Medicine*.

The original article alluded to a new technique, applicable for better localization and removal of radiopaque foreign bodies in the hand and fingers, but also in the knee area, the thigh, the buttocks, and the feet.

Subsequently, I have devised a simpler technique, eliminating the paper tracing process. Basically, my new method still involves preoperative preparation. Two sets of anteroposterior (AP) and lateral roentgenograms are taken. One set, of course, is for the record and medicolegal evidence. The second set is then used for a cut-out, following the soft tissue outlines of the anatomic part involved, be it the hand, foot, knee, thigh, or buttocks. Additionally, instead of a lead letter "O," a lead "dot" over the exact entrance of the foreign body is used whenever possible, to ascertain depth from skin level and various positions of the foreign body. The final preparatory step consists in making the cut-out from the x-ray film with fine scissors or

razor blade of both sites, the wound entrance as marked by the lead "dot," and the configuration of the foreign body on both AP and lateral projections. Lastly, these AP and lateral cut-out films are applied and superimposed as accurately as possible over the anatomic sites involved. The location of the entrance wound and the configuration of the foreign body are then marked through the cut-out aperatures with a noneradicating ink-marking solution. (The noneradicating, varicose-vein-marking solution prepared by our pharmacist consists of the following formula: pyrogallic acid 0.5 gm, acetone 5.0 cc, ferric chloride solution 4.0 cc, ethyl alcohol qs 10.0 cc.)

Following the outlined preparation, it is imperative that the operative procedure be executed, whenever feasible, in a bloodless field, as with a sterile, rubber-band tourniquet at the base of the finger, using local digital nerve block or a tourniquet to a drained venous extremity applied to the thigh or arm. Obviously, a bullet in the buttocks precludes this procedure.

As mentioned in my previous article (OSMJ, Sept. 1969 vol. 65, pp 906-907), surgical approach is made directly downward through the marked site to the depth required to locate and extract the foreign body. A bloodless field enhances identification of the foreign body and also decreases the chance of injury to vital structures.

Case Reports

Specific case histories and illustrations of foreign body, radiopaque glass are documented in cases 1 and 2,

Case 1.—A male employee, working on a bottle-production assembly line, incurred an injury one month prior to my initial examination. His complaint was that right lateral thumb pressure caused radiation pain to the thumb and to the forearm. Palpation at the lateral, second phalanx area was inconclusive. Querying this patient revealed that the injury was due to a possible brown, bottleglass splinter, rather than white glass. Accordingly, he was

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admitted to outpatient surgery, and following prescribed routine, two sets of AP and lateral x-rays of the hand, with special emphasis of the right thumb, were taken, revealing the glass foreign body ½ cm long and 5 mm wide, only in the lateral view of the right thumb. (See Fig. 1.) The cut-out x-ray film of the soft tissue, hand-and-thumb outline was accurately applied, and the cut-out aperture of the foreign body was marked with the non-eradicating solution on the skin. Rubber-band tourniquet was applied at the base of the right thumb to afford a bloodless field. Using local anesthesia, a transverse incision was made directly over the marked spot. Exposure of the lateral digital nerve encountered the spicule of glass, longitudinally embedded in the nerve. The extraction involved less than four minutes.

Case 2.—This 40-year-old man presented with two brown-bottle fragments in the right thenar palmar area and in the distal phlangeal, palmar area of the right middle finger. They were radiopaque only in the lateral view x-ray films. The cut-out x-ray localization, preoperative procedure was used for marking by the aforementioned technique (Fig. 2). A bloodless field could be achieved in this case only by applying a tourniquet to the right arm under general anesthesia. The brown-glass spicule in the right thenar eminence was extracted in two minutes, and the spicule in the right, middle, distal palmar area was located and removed in 30 seconds.

Case 3.—A 21-year-old male was referred to me by his physician, and x-ray films of his left knee clearly showed the distal half of a sewing needle embedded in a lateral position just below the knee. Routine, preoperative AP and lateral sets of x-ray films of the knee were made and used for marking (Figs. 3 and 4). Under general anesthesia and with a bloodless field, provided by a thigh tourniquet, the offending object was removed in a matter of minutes.

Case 4.—This represents a radiopaque foreign body, a bullet, lodged in the left gluteus maximus muscle of a 22-year-old woman. Inasmuch as no vital vessels, bones, or nerves had been traumatized, conservative management was followed, and the patient was released after three days of hospitalization. For the ensuing five weeks, the patient was unable to continue her occupation because of constant discomfort on standing or sitting. Rehospitalization was advised for elective removal of the foreign body, ie, a bullet. Again, diagnostic films were taken and, as noted on the x-ray film (Fig. 5), the bullet was localized approximately 3 inches medial and 3 inches deep from the "dot"



Fig. 1. Foreign body (brown glass) in lateral digital nerve of right thumb (case 1).



Fig. 2. Lateral view showing foreign bodies (brown-bottle glass) in right middle finger and right thenar (case 2).

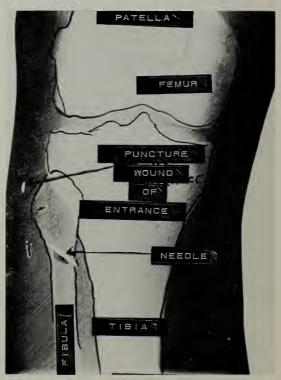


Fig. 3. Anteroposterior view of left knee showing embedded needle and wound entrance (case 3).

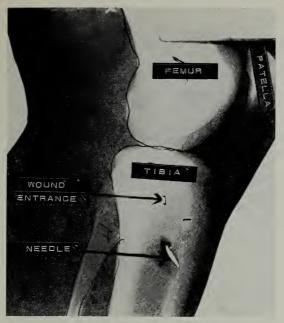


Fig. 4. Lateral view of left knee (case 3).

marking the wound entrance. The cut-out AP film of the soft tissue outline of the pelvis was then applied to the torso in the prone position, and the wound of entrance and the bullet site were marked. Under general anesthesia, an encapsulated, hard mass was felt deep in the gluteus maximus muscle and was held between the thumb and forefinger. This mass was incised, and an abscess with one-half ounce of purulent fluid was encountered. The offending bullet was removed in a 20-minute procedure. Culture and sensitivity tests proved this to be a sterile abscess and the cause of the patient's pain. My pathologist colleague, Dr. Jack Geer, advised photographing this foreign body and initialing it for medicolegal identification purposes.

Case 5.—A 16-year-old boy stepped on a sewing needle, lodging the distal 1½-cm portion below the second large-toe phalanx, in an oblique position. The cut-out film and marking technique was done preoperatively (Fig. 6). An incision was made through the marked site, and the needle was extracted in one minute, again using a bloodless field afforded by thigh tourniquet and general anesthesia.

Conclusion

The problem of locating and removing radiopaque foreign bodies from the human anatomy and animal anatomy presents a vexing problem to physicians and veterinarians. Incidentally, a veterinarian colleague and friend has used this technique with success. Wood, plastics, and even aluminum

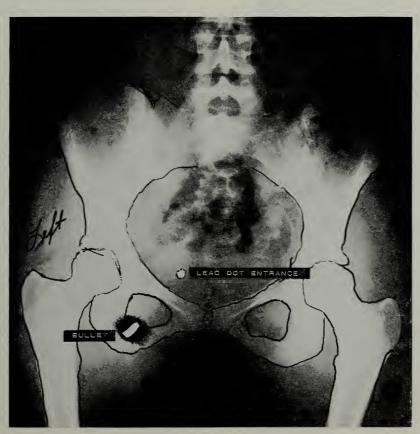


Fig. 5. X-ray film showing lead dot entrance and location of bullet (case 4).



Fig. 6. Anteroposterior view of distal end of right foot showing embedded sewing needle (case 5).

foreign bodies generally are not radiopaque and present difficult solutions. Glass, also, is not visible unless either lead or ferrous material has been used in the manufacturing process. But I do want to emphasize that repeated fluoroscopic extraction procedures are fraught with danger from overexposure to radiation, both to the patient and to the hands and fingers of the surgeon.

Also, it is a basic understatement to assume that physicians attempting foreign body extractions may not be faced with future claims, especially in unsuccessful procedures. Although I have never had a failure with this technique, which I have used in 24 cases, heretofore I have asked only for verbal consent from my patients. Legal opinion would indicate that written consent with no guarantee of success might be preferable. I am not egotistic enough to think that any technique is infallible.

Until a Geiger counter or similar locater is forthcoming to ferret out a better localization procedure for removing radiopaque foreign bodies, metallic and nonmetallic, I offer this innovative method to interested colleagues. And as they say on television commercials, "Try it. You may like it."

Nonspecific Recurrent Jejunal Ulceration

William Paul Skivolocki, M.D., Ph.D. Kenneth Sirinek, M.D. Thomas Brewer, M.D.

A patient with a perforated jejunal ulcer was treated by small-bowel resection. Postoperatively, a recurrent jejunal ulcer developed requiring resection of another segment of the bowel. Chronic alcoholism and long-term, high-dose thorazine ingestion are possible etiologic factors.

[EJUNAL ULCERATIONS not associated with the Zollinger-Ellison syndrome or status postgastroenterostomy are uncommonly reported lesions. Except for occasional ulcerations caused by enteric-coated potassium chloride and indomethacin, jejunal ulcerations are rare. The first description of nonspecific ulcerations of the small intestines was published by Baille in 1805. A review of the literature by Watson¹ in 1963 revealed only 170 cases of nonspecific jejunal ulcers. In 1964, Baker, et al² suggested an association between thiazide diuretics with enteric-coated potassium chloride and small-bowel ulcerations. This was substantiated in 1965 by a series of experimental studies using monkeys, in which the animals received entericcoated potassium chloride and subsequently developed small-bowel ulcerations.3

Further survey of patients with small-bowel ulcerations revealed that most patients were elderly

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and had associated cardiovascular disease. Experimental studies utilizing dogs showed that smallbowel ulcers similar to those produced by potassium chloride could be produced by ligating the terminal arterioles of the mesentery.4 This led to the conclusion that vascular insufficiency was another etiologic factor associated with small-bowel ulceration. No literature is available concerning the recurrence of a jejunal ulcer. This report describes the clinical course of a patient with a recurrent jejunal ulcer of undetermined etiology.

Case Report

A 38-year-old Negro man presented with the acute onset of colicky lower-abdominal pain associated with nausea following a drinking spree. The patient was a chronic alcoholic, had a past medical history of mental instability, and had been maintained on up to 1200 mg of thorazine daily. There was no past history of ulcer disease or other gastrointestinal signs or symptoms. There was no family history of ulcer disease.

On physical examination, the patient was a well-developed, moderately thin Negro man in acute distress. Although he was afebrile, the patient exhibited generalized abdominal tenderness, most marked in both lower quadrants. Rectal examination elicited a moderate tenderness over both iliac fossae

The upright abdominal film revealed free air under the diaphragm. As the pain became constant in nature, a tentative preoperative diagnosis of perforated colonic diverticulum was made, and the patient was prepared for surgery. At abdominal laporotomy, the patient was found to have bilious material in his peritoneal cavity. Inspection of the gastrointestinal tract revealed a perforation in the proximal jejunal wall. The segment of involved bowel in the area of the perforation was resected. Pathologic examination revealed excessive submucosal hemorrhage, peritoneal fibrinopurulent exudate, and ulceration of the mucosa and submucosa (Fig. 1). No other lesions of the upper gastrointestinal tract or pancreas were noted, and the liver appeared normal.

The patient's initial postoperative course was uneventful. However, on the tenth postoperative day, he developed acute upper gastrointestinal bleeding which required a transfusion of ten units of blood. At reoperation, a small ulcer cavity was found in the jejunum 2 cm proximal to the original ulcer site. This segment of jejunum was resected, and the patient had an uneventful postoperative

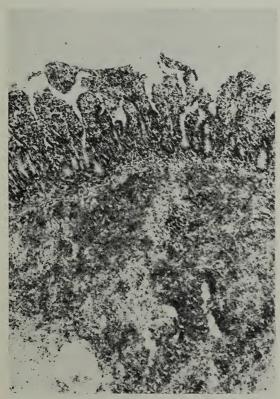


Fig. 1. Section of jejunum showing ulcer site with inflammatory reaction and hemorrhage; primary ulcer.



Fig. 2. Section of jejunum showing ulcer site with inflammatory reaction and hemorrhage; recurrent ulcer.

course. Pathologic examination of this specimen revealed hemorrhage into the mucosa and submucosa with numerous inflammatory cells associated with ulceration into the submucosa (Fig. 2).

Pertinent Laboratory Data: Electrolytes were all within normal limits. Serum potassium level was never below. 3.7 mEq/liter, blood urea nitrogen (BUN), and creatinine levels were normal throughout the patient's entire hospital stay, as were the serum amylase, bilirubin levels, liver function tests, serum alkaline phosphatase, serum calcium, and serum phosphorus values. A three-hour glucose tolerance test and plasma cortisol levels were all within normal limits. Twelve-hour gastric analysis done on three successive occasions revealed no free acid and a range of total acid from 24 to 50 mEq/liter. A fourth 12-hour gastric analysis done just prior to the patient's release from the hospital revealed 14 mEq/liter free acid and 46 mEq/liter of total acid. Basilar acid secretion and augmented histamine tests revealed a ratio of 18 percent. Upper gastrointestinal films taken after the second operation and repeated just prior to discharge were within normal limits. Barium enema disclosed mild sigmoid diverticulosis. Liver and pancreatic scan were within normal limits. Serum gastrin levels were not elevated.

Subsequent to his release from the hospital, the patient has been followed periodically for five years with no evidence of recurrent gastrointestinal disorder. Periodic serum gastrin levels and gastric analyses have been performed, and all have been within the normal range.

Discussion

Included in causes of jejunal ulcers are ulcerogenic pancreatic tumors, enteric-coated potassium chloride, indomethacin, and small vessel disease.

Ulcerogenic pancreatic tumors, as described by Zollinger and Ellison in 1955,5 are sometimes assosociated with jejunal ulcers. These ulcers are generally secondary to excess acid production by the parietal cell mass with a subsequent decrease in pH in the proximal jejunum followed by ulceration. Diagnosis of these cases is generally based on gastric analysis determinations and serum gastrin levels.

Enteric-coated potassium chloride has been shown to cause small-bowel ulcerations. Boley, et al6 demonstrated experimentally that the absorption of high concentrations of potassium chloride over a short segment of bowel was a factor in producing jejunal ulcers in dogs. In theory, the increased concentrations of potassium in venous channels resulted in spasm, stasis, submucosal edema, and finally ulceration. A review of 395 cases of patients with small-bowel ulcerations revealed that a significant number of these patients had received enteric-coated potassium chloride.

Indomethacin has also been associated with small-bowel ulceration. In 1966, Shack⁷ reported a case study where this anti-inflammatory agent (1-p-chlorobenzoyl-5-methoxy-2-methylindole-3acetic acid) was indicted as the causative agent for the patient's small-bowel ulcer and subsequent perforation. In rat experiments, Kent, et al⁸ suggested that the resultant small-bowel bacterial overgrowth seen with indomethacin may be associated with small-bowel ulcers. The exact pathogenesis is not clear; however, vascular lesions such as those demonstrated with potassium products were not noted.

Small vessel disease has been implicated as an etiologic factor in small-bowel ulceration. A large majority of patients with jejunal ulcerations are over 50 years old and have associated cardiovascular disease. Experiments with dogs have indicated a significant increase in severity and incidence of jejunal ulceration with potassium products if the splanchnic arterial pressure is reduced. These findings of Mansfield, et al9 support the concept of small-bowel predisposition to chemically induced ulceration in the presence of chronic vascular insufficiency. The findings of Boley, et al,6 showing wide divergence in amounts of potassium chloride and time needed to produce ulceration in their dog experiments, also suggest that underlying cardiovascular disease could make an individual prone to such ulcerations. The results of these studies suggest that mesenteric vascular insufficiency alone may produce small-bowel ulceration or that it may predispose the bowel to ulceration by other factors.

Charts were reviewed of all jejunal ulcer cases treated at The Ohio State University Hospitals during the past ten years. Those cases with associated Zollinger-Ellison syndrome and status postgastroenterostomy were excluded. Four cases with the diagnosis of nonspecific jejunal ulceration were found. One case was discharged as a possible Zollinger-Ellison syndrome, and three cases were diagnosed as primary jejunal ulceration. The present case makes a total of four cases of nonspecific jejunal ulcer of undetermined etiology seen at this institution in the past ten years. This patient was unique in that he had a recurrence of ulceration during the postoperative period.

The true pathogenesis of these ulcers still remains obscure. Although chronic alcoholism has not been reported as an etiologic factor, this aspect has not been fully investigated and, therefore, cannot be definitely ruled out. Also, no cases of thorazine-induced ulceration have been reported, and

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since this patient had been on high doses of thorazine, this remains a possible etiologic factor.

Summary

A patient with recurrent nonspecific jejunal ulceration has been reported. The patient presented with a perforated jejunal ulcer that was treated by small bowel resection. In the early postoperative period, the patient developed a recurrent jejunal ulcer that required resection of another segment of the bowel. Possible etiologic factors include chronic alcoholism and long-term, high-dose thorazine ingestion.

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The AMA House of Delegates, December 1974, adopted the following policy on "Service versus Medical Education":

"Resolved, That the American Medical Association reaffirm its concern for the quality of medical education through an appropriate balance between service and education by protecting the medical students' time which should be available for the acquisition of fundamental medical knowledge, from the inroads of repetitious service demands beyond that required to attain technical competence; and that it further request the Council on Medical Education in both the participation of its members on site visits and in membership on the Liaison Committee on Medical Education to continue to gather and evaluate data on this important issue."

Effect of Water Fluoridation on Urinary Tract Calculi

Jack L. Summers, M.D. Walter A. Keitzer, M.D.

A community with fluoridated water was studied over a five-year period and statistically compared with a neighboring nonfluoridated community with respect to incidence, location, and type of urinary-tract calculus. There were 1,252 calculi cases studied retrospectively.

MATER FLUORIDATION is currently accepted as a proven asset to the dental health of a community. Much controversy still exists, however, in some of the lay press, and in individual communities over its efficacy, effect on taste of the water, and overall value. One area that appears heretofore to be unexplored, by a review of the literature, is fluoridation's effect on urinary tract "stones" (or liths). We had a unique opportunity to statistically evaluate this parameter in our area. In 1968, the City of Akron, Ohio fluoridated their water at the accepted rate of 0.9 to 1.0 parts per million. The neighboring community of Cuyahoga Falls, Ohio did not. Since a large percentage of both communities' adult patients are admitted to Akron City Hospital, we felt it would give an adequate base for the study, using one community (Cuyahoga Falls) for control and the second community (Akron) for the study group.

Method

The charts of all patients admitted to our hospital with a primary or secondary diagnosis of

Submitted April 1, 1974.

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urinary tract calculus were reviewed, and were subjected to statistical analysis. The charts were separated into Akron and non-Akron residents, by the address listed on the chart. We could not consider length of time the individual lived at that address in the study. In all cases, the location of the calculus was noted, and when analyzed, the type of calculus was recorded.

Results

From a total number of 113,064 hospital admissions (84,798 Akron and 28,266 non-Akron residents), 8,356 were urologic patients (7.4 percent). Charts of 1,252 patients with urinary calculi were recovered. This represents 14.9 percent of urologic admissions; 71.7 percent were males and 28.3 percent were females. Eight hundred and thirty-seven calculi were ureteral, 327 were renal, 64 were bladder, and three were urethral in location. Of this total, 75.1 percent (940 patients) were Akron residents and 24.9 percent (312 patients) were non-Akron residents. Six hundred and thirty-one total calculi were recovered and analyzed (50.3 percent) of the total. Of those recovered, 68.2 percent were from non-residents, and 44.5 percent were from residents of Akron.

Results of the five-year analyses are summarized in Figures 1-3. The percentage of patients admitted from the two communities varies at 3:1, but it correlates well with the difference of population in the two communities.

Discussion

Any retrospective study can be subject to criticism, and by careful selection of study groups, one can usually find an appropriate sample to prove a given point. Since this study was conducted without preconceived ideas, and merely as a matter of curiosity, such criticism should not apply.

Many factors cannot be considered in this study, ie, the length of residency in a given area,

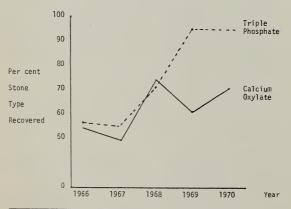


Fig. 1. Yearly recovery of triple phosphate and calcium oxylate calculi.

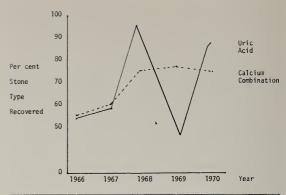


Fig. 2. Yearly recovery of uric acid and combination calcium calculi.

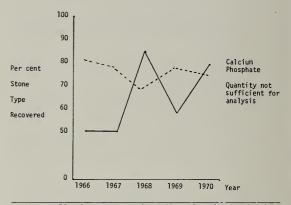


Fig. 3. Yearly recovery of calcium phosphate calculi and calculi too small to analyze.

amount of water consumed at the place of residency, amounts of fluoride in the diet, presence of vitamin A in diet, and actual urinary excretion rates of fluoride. It was only intended to see if there was a statistical correlation between numbers, location, and types of calculi in a fluoridated community versus a nonfluoridated one.

Fluoride is absorbed from the gut and 75 percent is excreted in the urine, the remaining in sweat. No known fluoride-free diet has yet been devised.

In the five years of the study, urologic admissions remained a constant 7 percent of the total admissions to the hospital. Of the urologic admissions, 15 percent represented urinary calculi from Akron and non-Akron residents. Although the total number of calculi varied from 291 to 217, the overall percentages remained constant in both communities. The overall incidence of urinary calculi in either community apparently was not influenced by fluoridation.

Urinary calculi were analyzed for location by the broad categories of kidneys, ureter, bladder, and urethra. These figures, likewise, remained constant over the five years, and no correlation with fluoridation could be found.

It was in the area of distribution of calculi types by chemical analysis that interesting findings were noted. Figure 1 shows a definite increase in the percentage of calcium oxalate and triple phosphate calculi recovered after the 1968 water fluoridation. The same finding regarding the various calcium combination calculi is noted in Figure 2. These represented calcium in varying combinations with magnesium, ammonium, oxalate, and phosphate.

As shown in Figures 2 and 3, calcium phosphate and uric acid calculi follow seminar, non-specific rates of occurrence over the study period.

No attempt will be made to explain the possible chemical relationships involved, since this would be pure speculation. However, it might be interesting to study other communities whose water systems are fluoridated to see if these trends can be duplicated, and to justify further investigation in this area.

Summary

A community with fluoridated water was studied over a five-year period and statistically compared with a neighboring nonfluoridated community with respect to incidence, location, and type of urinary-tract calculus. There were 1,252 calculi cases studied retrospectively.

No apparent correlation with incidence or location was found. A significant increase, however, in the percentage of calcium oxalate, calcium combination, and triple phosphate calculi was found after fluoridation of Akron's water supply.

The deficiencies of a retrospective study of this nature are pointed out. No specific conclusions are attempted due to their highly speculative nature, and it is hoped that other communities might be studied to see if these correlations can be duplicated and, thus, open a secondary avenue of investigation in this relatively unexplored subject.

Editor's Note:

The American Medical Association House of Delegates reaffirms and strengthens the present policy of the AMA reference fluoridation of public water supplies for the prevention of tooth decay. The following is the complete report accepted by the House of Delegates and is, therefore, the policy of the AMA reference fluoridation of public water supplies, as of December 1974:

"Few health measures have been accorded greater clinical and laboratory research, epidemiological study, massive clinical trial of total community populations, and public attention—both favorable and adverse—than the fluoridation of public water supplies.

"In 1957 the American Medical Association issued a position statement on fluorides and public water supplies (based upon what was then known through trial and study). It is timely to update this statement, since there now exists extensive additional experimental, clinical, laboratory and epidemiological data, confirming the safety and efficacy of this important essential nutrient.

"In evaluating these data, the AMA had directed major interest at the clinical effectiveness of fluoride in public water supplies; factors of safety; range of effectiveness, together with levels of toxicity or other undesirable effects. The mechanics and control of the addition or removal of fluorides from water supplies have been reviewed. A complete understanding of the range of safety and effectiveness as it relates to the population as a whole, all ages and states of health, has been recognized to be of primary importance.

"The recommended optimum concentration of fluoride in the water supply (0.7-1.2 ppm according to locality) should be consumed throughout life. This conclusion is based on epidemiological studies conducted in areas where fluoride occurs naturally in the water, and in areas where it has been added at the recommended level by mechanical means. Numerous controlled fluoridation programs, some in operation since 1945, have been evaluated as successful in reducing and/or preventing dental caries.

"Only when relatively large amounts of fluoride (8-20 mg/day) are ingested over periods of 10 to 20 years are any generalized adverse effects encountered. No adverse effects have been reported when water containing optimum levels of fluoride has been drunk during periods of 10 to 20 years. Fluoride-induced motling of tooth enamel has been reported only when fluoride concentration in the water exceeded 1.4 to 1.6 ppm.

Research has established that people consuming water containing the optimum level of fluoride experience no adverse effects on their kidneys, thyroid glands, reproductive functions, growth, development, blood, urine or hearing. No cases of allergic reactions have been linked with consumption of water fluoridated at the recommended levels.

"Research has also provided evidence that suitable amounts of fluoride may be helpful in preventing or alleviaitng bone diseases such as osteoporosis, especially in our aging population.

"Equipment has been developed, reliable analytical procedures are available, and appropriate safeguards have been established to assure that fluorides can be safely added to public water supplies at the optimum level.

"The AMA has critically reviewed this subject in its entirety. It has taken cognizance of what has been done, as well as carefully weighing the comments and the scientific evidence of those who oppose fluoridation, in order to maintain an objective attitude concerning this important health measure.

"No other alternatives or techniques for the provision of fluorides can at present replace the fluoridation of drinking water as an effective and practicable public health measure. When water fluoridation is not feasible, other means of supplying the proper amount of fluoride should be employed.

"On the basis of this careful analysis of information, the AMA considers the fluoridation of public water supplies at the recommended rate to be a desirable and safe health measure for total populations, and urges all communities to take necessary actions."

R.L.M.

Final Regulations For Medicare-Medicaid Review

The controversial pre-admission certification requirement suggested in proposed rules is not contained in the final regulations for Medicare-Medicaid review for hospitals and skilled nursing facilities. Published in the November 29, 1974 Federal Register, the regulations are effective February 1.

Under the new regulations, hospitals will be required to undertake concurrent admission review, with approved length of stay based on a patient's condition and diagnosis. They must also conduct a review of a patient's need for continued hospitalization, according to criteria developed by the review committee, and retrospective review of the quality of care through medical care evaluation studies. Composition of the utilization review committee has been changed to allow professional personnel employed by hospitals to be members.

In addition, under Medicaid, states will be required to establish utilization control programs including provisions for: physician's certification, at admission and every 60 days thereafter, of a patient's need for institutional care; development and review of a plan of care for each patient; and on-site inspections to determine adequacy and quality of services.

The Department of Health, Education and Welfare said the new rules "are compatible with and supportive of HEW's Professional Standards Review Organization program, and will permit an orderly transition to the operation of the PSROs." They are also designed to be applicable to all patients and to fit in with any future national health insurance program.

AMA Approves Definition of Family Physician

At its Clinical Convention in Portland, the American Medical Association approved the following definition of the family physician.

The family physician is a physician who practices in the discipline of family practice, and whose training and experience qualify him to practice in several fields of medicine and surgery, with particular emphasis on the family unit, and who:

- a. Serves the public as a physician of first contact and means of entry into the health care system;
- Evaluates his patient's total health needs, providing personal medical care within one or more fields of medicine, and refers the patient when indicated to appropriate sources of care while preserving the continuity of his care;
- c. Assumes responsibility for his patient's comprehensive and continuing health care and acts as coordinator of his patient's health services; and
- d. Accepts responsibility for his patients' total health care, including the use of consultants, within the context of their environment, including the community and the family or comparable social unit.

The U.S. infant mortality rate was at a record low during the first six months of 1974. It was 17.1 per 1,000 live births, compared to 17.9 for the same period in 1973.



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Proceedings of The Council

Meeting of October 26-27, 1974

A REGULAR MEETING of the Council of the Ohio State Medical Association was held Saturday and Sunday, October 26-27, 1974, at the OSMA Headquarters' office, 600 S. High Street, Columbus, Ohio.

Those present Saturday were: All members of the Council (with the exception of Dr. Lieber); Mr. Guy D. Beaumont, Jr., Columbus, Field Representative, AMA Public Affairs Division; John W. Cashman, M.D., Columbus, Director, Ohio Department of Health; Mrs. Charlotte Glueck, Springfield, President of the Woman's Auxiliary to the OSMA; Richard L. Meiling, M.D., Columbus, Chairman, Ohio Delegation to the AMA; Henry A. Crawford, M.D., Cleveland; Harry K. Hines, M.D., Cincinnati; Robert N. Smith, M.D., Toledo; Richard L. Fulton, M.D., Columbus, members of the Ohio Delegation to the AMA; Homer S. Harrison, Columbus, Vice President, External Relations, Ohio Medical Indemnity, Inc.; Dwane R. Houser, Vice President, Operations, Ohio Medical Indemnity, Inc., and Messrs. Page, Edgar, Campbell, Clinger, Rader, Houser, Holcomb, Mrs. Wisse, Mrs. Dodson and Mrs. Tanner, all members of the OSMA Staff.

Those present Sunday were: All members of the Council (with the exception of Dr. Wells);

James E. Pohlman, Esq., Columbus, OSMA Legal Counsel; Mr. Beaumont; Mrs. Glueck; Anthony Ruppersberg, Jr., M.D., Columbus, Chairman, OSMA Committee on Maternal Health; Luther W. High, M.D., Millersburg, Chairman of the OSMA Committee on Public Relations; Messrs. Page, Edgar, Campbell, Clinger, Rader, Holcomb, Mrs. Wisse and Mrs. Dodson.

The meeting was called to order by President Henry.

The minutes of the September 20-22 meeting of the Council were approved.

Membership

Mrs. Wisse announced that both OSMA and AMA membership in Ohio is well ahead of last year's October 15 figure.

Fiscal Matters

Dr. Wells reported on fiscal conditions and urged officers and staff to conserve assets and cut expenses.

American Medical Association

Dr. Meiling reported on the October 25 meeting of the AMA Delegation. Four resolutions from the Delegation were accepted by the Council for

presentation at the December meeting of the American Medical Association, entitled:

- Category I Continuing Medical Education Credit.
- Active Opposition to Governmental Control of Medicine, Licensure, Certification, et al.
- 3. Repeated Failure to Comply with the Recommendation of American Medical Association House of Delegates.
- 4. Definition of the Authority of the House of Delegates Over the Judicial Council.

A motion to support the candidacy of Dr. Budd for the June, 1975 office of President-Elect of the AMA, provided that he agreed to be a candidate, was adopted by the Council. Dr. Meiling communicated with Dr. Budd and Dr. Budd advised him that he would not be a candidate for President-Elect of the AMA in June.

The report of Dr. Meiling was accepted.

OSMA Annual Meeting

A progress report on the 1975 Annual Meeting and exhibits was presented by Mrs. Dodson and was accepted.

The Council received from the Academy of Medicine of Toledo and Lucas County, the nomination of George N. Bates, M.D., Fourth District Councilor, as a candidate for the office of President-Elect of the Ohio State Medical Association.

MAI/Peer Review Systems

Dr. Clarke reported on Medical Advances Institute Board Meetings of September 25 and October 23.

Ohio Medical Indemnity

Homer S. Harrison, Vice President-External Relations and Dwane R. Houser, Vice President-Operations, Ohio Medical Indemnity, Inc., appeared before the Council to discuss the "usual, customary and reasonable" plan of Ohio Medical Indemnity, Inc. Mr. Harrison announced that, in the beginning, there were 17 geographic areas and by 1972, there were four areas: large metropolitan; medium metropolitan; rural and "statewide." Currently, according to Mr. Harrison, 98 percent of the benefits are paid in full under UCR contracts. He stated that UCR contracts are "experience rated" on the anniversary date of the policy each year. This procedure provides that beneficiaries in areas where lower UCR benefits are paid, pay a lower premium for their policies.

The Council unanimously reaffirmed support of the "usual, customary and reasonable" principle of Ohio Medical Indemnity, Inc., and suggested that Ohio Medical Indemnity invite two physicians who have questioned the UCR procedure to confer with senior staff officials of OMI concerning the problem.

Ohio Foundation for Medical Care

Minutes of the meeting of the Board of Trustees of the Ohio Foundation for Medical Care, held October 2, were presented by Mr. Campbell.

The Council adjourned and the members of the Ohio Foundation for Medical Care were con-

After the meeting of the corporate members of the Ohio Foundation for Medical Care was completed, the regular meeting of the Council was reconvened.

Committee Reports

Ad Hoc Committee on Constitution and Bylaws Revision and Professionalism

A progress report on the proceedings of the Ad Hoc Committee on Constitution and Bylaws Revision and Professionalism meeting, held September 29, was presented by Dr. McLarnan.

Committee on Government Medical Care Programs

The minutes of the Committee on Government Medical Care Programs meeting of October 2, were presented by Mr. Houser. Mr. Houser announced that a communication with regard to the Civil Rights Pledge controversy is being prepared by Legal Counsel for presentation to the Ohio Department of Public Welfare.

A recommendation of the Committee concerning "Early Periodic Screening Diagnosis and Treatment" was amended by the Council and passed as follows: "That the OSMA encourage physicians to become familiar with and to participate in the Early Periodic Screening Diagnosis and Treatment national program amendments to Title XIX (Medicaid) of the Social Security Act, with the screening being done by the recipient's personal physician." One negative vote was recorded (Dr. Pichette).

Joint Advisory Committee on Sports Medicine

The minutes of the Joint Advisory Committee on Sports Medicine meeting held October 2, were presented by Mr. Clinger. The Council agreed to purchase a video tape of a Sports Medicine Conference.

The report as a whole was accepted.

Committee on Hospital Relations

The minutes of the Committee on Hospital Relations meeting of October 23, were presented by Mr. Houser.

The following recommendations of the Committee were accepted by the Council:

"1. That the work done by the Ohio Hospital Association is approved favorably by the Committee on Hospital Relations from the standpoint that, if legislation is introduced at all pertaining to licensure, certificate of need,

and quality assurance, it should be introduced as separate bills and that the Ohio Department of Health's proposed bill of April 12, 1973, is unsatisfactory. The present thinking of including "certificate of need" in a licensure bill, is not satisfactory. The committee does approve the basic work done by the OHA that if legislation is introduced it should be introduced in separate bills.

"2. If a bill on licensure is introduced, the committee feels that it must contain the specifics of exceptions, namely, that physicians' offices be exempt. And if further exemptions must be specified the exceptions that were developed by the Task Force and incorporated in the April 12, bill could be considered.

"3. Support the thesis that Ohio does not need certificate of need legislation."

The report as a whole was accepted for information, contingent on further research by Dr. Morgan.

Committee on Membership and Planning

A report of the Committee on Membership and Planning meeting of October 25, was presented by Mr. Page and was approved.

In adopting the report, the Council approved four recommendations concerning the operation of the Annual Meeting; asked the Committees on Public Relations and Scientific Work to develop a bicentennial program involving the participation of physicians in Ohio's history for the 1976 Annual Meeting; engaged the services of Richard L. Meiling, M.D., as Consulting Medical Editor of The Ohio State Medical Journal; adopted concepts with regard to the mission of The Ohio State Medical Journal; authorized the Chairman of the Membership and Planning Committee and the Executive Director to set up a system of job descriptions, forecast of department objectives and staff evaluation; gave permission for a survey of the membership, similar to that conducted in 1970, and approved the development of mechanisms to enhance the relationship of medicine and its allies.

Federal Legislation

Mr. Edgar reported on the defeat of S.R. 3585 by the substitution of the Beall Bill. He announced that H.R. 16204 awaits a place on the House calendar.

Mr. Beaumont supplemented the report with regard to Program Review Teams. It was the consensus that if these problems can be avoided by direct billing, OSMA communications should so emphasize.

State Legislation

The Council directed the staff to develop a statement on chiropractic for the next meeting of the Council.

The staff was also directed to determine if certain hospitals were permitting chiropractors to practice on their staffs, and, if so, the hospital staff involved be referred to the county medical society and to the Committee on Judicial and Professional Relations for appropriate review.

Constitution and Bylaws

Proposed amendments to the Constitution and Bylaws of the Mahoning County Medical Society were presented to the Council. The Council decided to suggest to the Society that a policy statement in the minutes of the organization would be preferable to changing the Bylaws with regard to election procedures. Dr. Pichette agreed to discuss this matter with the Society.

Legal Counsel Reports

Legal Counsel reported that the Court of Appeals reversed the decision of the lower court in Lorain County in the case of Gotsis V. Lorain County Medical Society and that the three judges of the Court of Appeals stated in their opinion that the disciplinary procedures of the model county medical society bylaws fully protected the constitutional rights of the members.

Field Service Report

The Field Service Report was presented by Mr. Holcomb. He stated that he had scheduled 12 county medical society meetings between October 25 through December.

Ohio State Medical Journal

Mrs. Tanner reported on The Ohio State Medical Journal advertising revenues.

Prescribed Course in Anesthesia

Dr. Ruppersberg addressed the Council with regard to interpretation of the term "a prescribed course in anesthesia" and "a hospital in good standing," under the provisions of Section 4731.35 of the Ohio Revised Code. The Council recommended the following to the Ohio State Medical Board as its interpretation of the above language in the Code. Such recommendation is contingent upon consultation with the Ohio Society of Anesthesiologists. The suggested interpretation of "a prescribed course in anesthesia," as recommended by the Committee on Maternal Health, is that such nurse be "a certified graduate of a prescribed course in anesthesia approved by the American Association of Nurse Anesthetists, or its equivalent."

Pike County NHSC

The Council endorsed the request for National Health Service Corporation assistance in Pike County, Ohio. Such assistance was previously

endorsed on October 1, 1974 by the Pike County Medical Society.

grant Other Co.

Woman's Auxiliary

Mrs. S. J. Glueck, President of the Woman's Auxiliary addressed the Council. She described the Health Education Program of the Auxiliary and discussed the programs conducted by the Ohio Council of Churches. The Council thanked her for her report and her interest in the work of the Association.

Ohio Director of Health

John W. Cashman, M.D., Ohio Director of Health, addressed the Council. He spoke of the Governor's interest in improving health care in three areas:

- 1. Development of Emergency Medical Care
- 2. Re-emphasis on the desire for expanded home health care program.
- 3. Recognition and eradication of communicative disorders of children.

He discussed certain problems with regard to the role of local health departments in the 1970's and 1980's. He spoke of the lack of prenatal and well child clinics and discussed the lack of interest on the part of township trustees, county commissioners and local health commissioners in developing these programs.

He indicated that he would discuss licensure and certificate of need legislation with interested associations to the end that something palatable to all groups may be adopted.

Dr. Cashman indicated, in answer to a question by Mr. Clinger, that he would support the concept of a K-12 curriculum in comprehensive health education for Ohio schools as requested by the Ohio State Medical Association House of Delegates.

In answer to questions on certificate of need involving physicians' offices, Dr. Cashman replied "I don't intend to do anything about doctors' offices."

Anti-Substitution Laws and Regulations

The Council endorsed a joint statement on anti-substitution laws and regulations, previously approved by the American Medical Association and a number of other medical organizations.

Proposed Public Relations Program

A proposed Public Relations Program for the Ohio State Medical Association was presented by Luther W. High, M.D., Chairman of the Committee on Public Relations of the Ohio State Medical Association. The report was accepted with praise.

Policy on Mailing Lists

The Council adopted the following policy with regard to the request from members for mailing lists of the members of the Ohio State Medical Association: "The full mailing list will be available to members, at an appropriate price, on request. The member must agree not to sell or resell the list. Requests from other than members will continue to be handled by the Council on an individual basis, provided that the officers can act in an emergency." It was pointed out that the staff may inform members that alternative lists, such as the Ohio State Medical Board Roster and the AMA approved mailing list companies, also are available.

Highland County

The Council was convened in Executive Session to consider an Anesthesia Review of Highland District Hospital. The report was amended, then approved, for transmittal to the appropriate parties.

The Council reconvened in regular session.

Harrison County Society Problem

With regard to the Harrison County problem, the Executive Director was instructed to write to the doctor involved for detailed information on salary and other arrangements.

In-Hospital Indemnity Insurance Program

The Ohio State Medical Association sponsored In-Hospital Indemnity insurance program was amended to provide a \$90 a day plan in addition to the present \$30 and \$60 plans.

Gastrointestinal Endoscopy Society

The Council received a letter from Dr. James F. King, announcing the formation of the Northeastern Ohio Society for Gastrointestinal Endoscopy. The Council wished the organization well and offered the assistance of the Ohio State Medical Association.

HMO Draft

The Council received a draft of a Health Maintenance Organization legislative proposal from the Department of Insurance. It was indicated that the draft contained some of the changes requested by the Ohio State Medical Association. The Council voted to continue to insist on OSMA amendments.

The Council then convened in Executive Session, reconvened in regular session and adjourned.

> ATTEST: Hart F. Page Executive Director

IMPORTANT INFORMATION: This is a Schedule V substance by Federal law; diphenoxylate HCI is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCI) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCI may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCI and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCI is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

Dosage and administration: Lomotil is contraindicated in children less than 2 years old. Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCI with 0.025 mg. of atropine sulfate. Liquid, 2.5 mg. of diphenoxylate HCI and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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MD's Take Note

Federal Act Gives Students Access To Medical Records

A Federal Act that became effective November 19, 1974, provides that parents of a student or a student of majority age may inspect an educational institution's files on that student, including any medical records.

Such inspection is provided by the Family Educational Rights and Privacy Act of 1974, which also states that any school which denies parents' or a student's request to see such files will lose all federal funds it is receiving.

Physicians should be aware of the law since they might enter into a student's medical records information which physicians feel should, for medical reasons, not be made available to parents or the student.

An educational institution has 45 days to respond to a request for access to a student's files.

Several national organizations representing education on the primary, secondary and university levels are seeking amendments to the law. They contend the law is unclear, opens institutions to requests that could border on the ridiculous, and requires remedial amendments.

Sponsors of the legislation cited cases where files containing false or derogatory information jeopardized the student's future.

'Deadlier Flu' On Way

Influenza warnings are now up, reports the Health Insurance Institute. A new type A strain called Port Chalmers flu is expected to sweep most of the nation this winter. According to the Center for Disease Control, this flu is deadlier than most of the others and more likely to strike adults than children.

But, says the CDC, it may be controllable with a flu vaccine that offers protection against this new strain.

Port Chalmers flu was first isolated in New Zealand, appeared this summer in Georgia and Mississippi and is expected to spread through the South, Midwest, and Pacific Coast.

From 1967 through September, 1974, prescription prices in the United States increased less than five percent (based on Bureau of Labor Statistics). In 1973 the consumer paid about the same per capsule of medication in the average prescription as he or she did five years ago (based on the average prescription price in 1973 of \$4.54).

Report On

AMERICAN MEDICAL ASSOCIATION CLINICAL CONVENTION

PORTLAND, OREGON

DECEMBER 1-4, 1974

YOUR EIGHT OSMA DELEGATES and EIGHT ALTERNATE DELEGATES represented YOU at the Clinical Convention of the AMA HOUSE OF DELEGATES MEETING IN PORTLAND, OREGON — DECEMBER 1-4, 1974. The BUSINESS before the House of Delegates included 79 reports and amendments of the Board of Trustees, Councils and Committees of the AMA, 69 resolutions from the 50 state medical societies, 4 from the territorial societies, 26 from the specialty sections, 1 from the medical student organization, 1 from the intern and resident business section and 1 item of unfinished business (constitution change involving meetings of House of Delegates).

Additional members of OSMA who served as delegates or alternate delegates were as follows:

Cardio-Vascular Disease

Neurological Surgery

Obstetrics & Gynecology

Ophthalmology

Otorhinolarynogology

Medical Students

William A. Sodeman, M.D. (Del.) Lucas County

Frank H. Mayfield, M.D. (Del.) Hamilton County

Richard T. F. Schmidt, M.D. (Alt. Del.) Hamilton County

Charles E. Jaeckle, M.D. (Alt. Del.) Defiance County

Walter H. Maloney, M.D. (Del.) Cuyahoga County

Mr. Russell Kridel (Del.) Hamilton County

THE OHIO DELEGATION INTRODUCED 3 RESOLUTIONS:

SUBJECT

- 1. AMA opposition to federal legislation involving control of licensure, certification, geographic assignment of physicians, limitation of post physician education. The Congress on December 4, 1974 began floor debate on HR 17084 Health Manpower and HR 16204 Health Planning which have matching bills S 3585 (substitute) and S 2994 in the Senate.
- 2. A constitutional interpretation involving House of Delegates and Judicial Council of the House of Delegates.
- 3. AMA system of prior approval of OSMA continuing medical education program.

ACTION TAKEN

Referred to Board of Trustees and Council on Legislation

Referred to Council on Constitution and Bylaws

Not adopted

The Ohio Delegation supplied one member to Reference Committee (A) on Insurance and Medical Service and also supplied the Chief Teller for the House of Delegates.

A Summary of Major Issues

FISCAL

Note: The AMA has no cash to meet daily operating expenses. The AMA had no ready cash reserve for the months of October and November, 1974. The AMA has borrowed \$1,000,000 per month for October, November and December, 1974 to meet operating expenses.

- 1. The House approved a \$60.00 assessment effective January 1, 1975. The AMA will bill members for this assessment directly from AMA Headquarters.
- 2. The House of Delegates placed on the agenda for the Annual Meeting in June 1975, the subject of increased annual dues to be accompanied by adequate financial background material provided by the Board of Trustees.
- 3. The AMA Council on Constitution and Bylaws advised the House of Delegates that, in the opinion of that Council, the action taken by the House directing the Board of Trustees to rescind its "economy actions" involved financial responsibility, which by Illinois Law and AMA constitution is vest in the Board of Trustees. The action was therefore unconstitutional.

The Board of Trustees meeting, following the conclusion of the House of Delegates Clinical Convention, then increased JAMA from 48 to 52 issues, Prism from 10 to 12 issues, and changed three specialty journals from quarterly to monthly publications. The Board decided to place all AMA publications except JAMA, American Medical News, and Today's Health on a subscription basis as soon as possible.

The eliminated Councils and Committees will be held on a "standby status" pending review and recommendations of the ad hoc committee of the House, appointed to consider this matter.

The Speaker appointed Reference Committee F of the House, plus three additional members of the House, to serve as this "ad hoc" committee and to report their findings and recommendations at the Annual Convention in June 1975.

GENERAL

- 1. Approved a resolution regarding Medical Audit and Utilization Review Procedures.
- 2. Referred to The Judicial Council and The Council on Medical Service the problem of physicians involved in educational billing for services rendered by interns and residents.
- 3. Refused to adopt a resolution proposing legislation to alter, in some states, the reimbursement concept as it would apply to Blue Cross reimbursement to Surgicenters.

- 4. Established a definition of FAMILY PHYSI-CIAN.
- 5. Voted to publish a progress report on evaluation of PSRO programs.
- 6. Voted that acupuncture is an experimental medical procedure and should be confined by legislative action to the research setting.
- 7. Defeated a proposal to ask State Legislators to legislate the awarding of M.D. degrees for F.M.G. and Osteopaths.
- 8. Voted that recertification of medical specialists should, when undertaken, be based on performance, documented constructive medical education and competence in patient care rather than on a written program emphasizing "knowledge or recall" of the examinee.
- 9. Adopted "guidelines" for information only of both parties involved in contractual arrangements between post M.D. students, (interns, residents, etc.) educators, hospitals or other patient care facilities. The informational "guidelines" do not recommend union type contracts, collective bargaining or payroll dues check off unless both parties subscribe to such provisions prior to entering into a contract.
- 10. Voted that "moon lighting" on off-duty hours and extra-mural activities may be negotiated between the two parties (the resident and the hospital) to a contract so long as the primary institutional responsibilities and the education responsibilities are not compromised.

Note: House staff may spend off duty hours as they see fit. But, IN OHIO, unless the intern or resident has a valid Ohio License to practice medicine as differentiated from a "certificate" to practice in a specified educational setting, hospital or clinic for a specified time period, he may not legally practice medicine in his off duty hours regardless of the "supervision" of a licensed practicing physician.

- 11. Reaffirmed policy on definition of Death Death cannot be statutorially defined and the clinical judgment of the physician should prevail.
- 12. Voted that continued acceptance of advertising in medical journals is a proper function of both advertisers and publishers.
- 13. Maintained separation of AMPAC from AMA Legislative Council. Administration of AMPAC will be housed in the 535 North Dearborn building.

Note: The 1975 AMA budget as currently appoved provided "A GRANT" of \$746,000.00 to provide "educational and administrative support" to AMPAC. (Continued)

(Continued)

- 14. Professional Liability Inurance:
 - The Board of Trustees stated this was a serious problem and that they were assigning the highest priority to its resolution. The House of Delegates recommended that each State Medical Association seek legislative remedy to the complex and serious crises involving *Professional Liability*.
- Reaffirmed positive position on fluoridation of Public Water Supply.
- Referred questions involving prostitution and homosexual activities of consenting adults to the Board of Trustees for additional study.
- 17. Voted that physicians may, by placing an explanation on his professional fee statements (notification in advance) add a "service charge" for the cost of rebilling.

Note: The Judicial Council statement added to its 1962 opinion: "It is not improper, however for a physician to add a service charge, equal to the actual administrative cost of rebilling, on accounts not paid within a reasonable time. Patients must be notified in advance of the existence of this practice."

- 18. Filed the report of AMAERF regarding continuing progress in funding of medical education via the loan guarantee program.
- 19. Referred to the Council on Constitution and Bylaws the proposal of the AMA Board of Trustees to Amend Article II of the "objects" of the AMA (the "betterment of public health") to substitute the statement "to improve the quality of life." (The reference committee heard lengthy testimony on the broad, almost unlimited, responsibilities involved in "quality of life" programs. Only AMA staff individuals and one member of the Board of Trustees spoke in favor of the proposal. Many delegates felt that such unlimited responsibilities were beyond the financial and professional capabilities of the medical profession).

Your OSMA Delegation spent more than **561** man hours in four days of official meetings at the AMA Clinical Convention in Portland, Oregon on **YOUR** behalf.



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WRITE FOR LITERATURE AND SAMPLES

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Who Contributes to the Malpractice Crisis? Is This a Type of Contribution?

The "publicity hungry" physicians who respond to news media's requests for "expert medical opinions," or even volunteer such opinions, are contributing to the malpractice crisis. The recent rush to be a "headliner" or expert television commentator on the subject of the care and treatment of the wife of the President of the United States, the wife of the Vice President designee, or the former President is a case in point. Each of these patients is entitled to patient-physician confidentiality. Physicians who publicly criticize the professional care given a patient by another physician (whether in news magazines, newspapers, television programs, or as "case" discussions in educational groups) are inviting the "suit-prone" public to file claims regardless of the quality of medical care received.

One writer, in by-line articles in The New York Times on November 16 and 30, 1974, reviewed the medical reporting of Mr. Nixon's case. This writer cited faculty members from two eastern medical schools who, without knowledge of Mr. Nixon's condition, centered their criticism on the choice of the vein on which a clip was placed. The Times article further found this medical criticism to be a conflict of several factions: town and gown, doctors practicing on a fee for service privately and those salaried by medical faculties (all medical faculties receive public funds); the eastern medical profession and the western medical profession; University teaching hospitals and Community (teaching) hospitals; and those demanding consultation in each and every special discipline and for each and every step or procedure.

In the face of sharp criticism from the eastern based media, the three court-appointed medical experts who examined Mr. Nixon very correctly preserved the confidential nature of the doctorpatient relationship. They reported only to the court on their findings concerning the diagnosis and prognosis in the case of the former President. The public statements of these medical experts are exemplary guides to other physicians who may be in a similar position.

For those colleagues who may be tempted to become a public medical expert, it might be wise to remember this American Indian Prayer:

"OH GREAT SPIRIT, GRANT THAT I MAY NOT CRITICIZE MY NEIGHBOR UN-TIL I HAVE WALKED A MILE IN HIS MOC-CASINS."

> Richard L. Meiling, M.D. Consulting Medical Editor

Organizations looking for speakers to participate in continuing medical education sessions can contact the American Society for Clinical Pharmacology and Therapeutics. The Society offers a Speaker's Bureau and will provide programs directed toward the practicing physician.

The host organization is responsible for providing honoraria and travel expenses for guest speakers. Applications for speakers should be made well in advance of the date of the meeting.

Anyone interested in utilizing this service should contact: Mrs. Elaine Galasso, 1718 Gallagher Road, Norristown, Pa. 19401.



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HEALTH POWER PLANNING, AND RESOURCES DEVELOPMENT LEGISLATION!!!

N SEPTEMBER 1974, two separate bills were debated and approved by the Senate · S3585 and S2994!!!

Additionally, two separate bills were debated before the House in December 1974 —H.R. 17084 and H.R.16204!!!

THE OHIO STATE MEDICAL Association has opposed the philosophy and policies espoused in each of these bills as a growing, continual encroachment of the Federal government on the rights of the physician, the resident, and the medical student. These bills also encroach upon health care delivery systems, the patients, our present hospital systems, and our medical educational programs.

THE OHIO STATE MEDICAL Association successfully introduced a resolution to reaffirm the American Medical Association's opposition to the philosophy and policies of these four legislative bills.

Health legislation of overwhelming importance to physicians will be brought before the 94th Congress, which convened this month.

A national health program is considered high priority. A national medical manpower program was passed in December 1974. A national, mandatory health services and facilities planning program was also passed last month.

Legislation in the medical manpower area and compulsory health planning represent serious federal inroads into the control of medical education, medical services, and medical facilities.

Legislation establishing a national health program failed not because a majority of the Congress opposed it but only because of a lack of a majority agreement on what type of program to legislate.

The accepted manpower bill was somewhat watered down. However, it gives Washington control over the locations, types and numbers of residency programs. Originally, it would have mandated medical schools to require all medical students to agree to practice for two years in a geographic or service area designated by the Secretary of Health, Education and Welfare. It is also designed to curb the influx of foreign medical graduates. It would have limited the number and location of all residents in training, and placed mandatory federal controls on relicensing and recertification.

The health planning bills may have resulted ultimately in regulation of all health care delivery by HEW.

Objectionable features include:

Control of medicine and all health care services and facilities under a federal "public utility" concept.

Federal control of health care planning and regulation.

Mandatory certificate of need legislation in every state.

Fixed rates for all health services, with those rates based on federally dictated criteria.

In the area of a national health care program, the enlargement of the House Committee on Ways and Means by the addition of liberal Congressmen and the division of the Committee into subcommittees (long prevented by former Chairman Mr. Wilbur Mills) all spell early attention to a national health care bill.

The American Medical Association has established a set of 14 principles essential for any national health care program. They are:

- 1. Minimum federal involvement in administration of any program.
- 2. State jurisdiction of licensure and certification of professional health personnel and regulation of insurance.
- 3. Minimum federal tax dollars in financing programs for comprehensive coverage at least possible cost.
- 4. Multiple funding through federal, state and private funds, including (a) employer-employee payments for private health insurance and (b) individual tax credit as applied for full health care protection.
 - 5. No added Social Security tax for financing.
 - 6. No administration by Social Security.
- 7. Cost sharing by participants with a subsidy for the indigent scaled according to income.
- 8. Use of private insurance on risk and underwriting basis.
- 9. Comprehensive coverage, basic and catastrophic, for the entire population.
- 10. Pluralism in methods of health care delivery.

- 11. Cost controls as appropriate.
- 12. Quality controls as appropriate.
- 13. Continuity of benefits.
- 14. Coordination of benefits.

"Every physician, if his rights to practice his profession in an atmosphere of liberty and his rights to determine the value of his professional services are to be preserved, will have no choice but to follow closely and actively support the recommendations of the Ohio State Medical Association and the American Medical Association in regard to federal legislation," warns Ohio State Medical Association President James L. Henry, M.D."

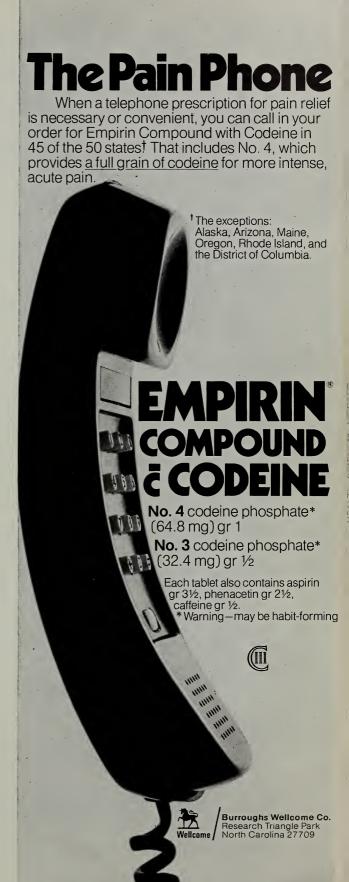
Dr. Henry said, "In my long experience of resisting federal government efforts to control peer review, it is my considered conclusion that the federal officials deeply fear a strong, independent, physician-directed peer review system. A physician-established and physician-operated peer review system to assure quality of care can be the most effective method whereby we physicians can stand solidly between our patients and the federal government. Otherwise, government will stand between physician and patient."

Dr. Henry predicted that 1975 will be the most critical year in the long history of American medicine's long struggle to preserve its freedom. "We can convince Congress that there is overwhelming grass roots support among our patients for their rights to be served and our rights to serve them in an area of professional independence and responsibility."

Dr. Henry said the only way this can be done is for all physicians to (1) become well informed on the legislative issues, (2) talk effectively to their Congressmen and Senators, (3) inform all patients and solicit their active support of an independent medical care system, (4) inform and enlist the active support of all community leaders. He concluded, "This is not just a one-time program. We must mount and wage an unceasing campaign to preserve our professional independence. Any physician who does not want to get personally involved should consider, very deeply and very seriously, the alternative, if there is an alternative."

Kenneth S. Warren, M.D., associate professor of medicine at Case Western Reserve University, was honored by the American Society for Tropical Medicine and Hygiene in Honolulu. He received the society's Bailey K. Ashford medal for "excellent internationally recognized work in tropical medicine."

Dr. Warren is an authority on schistosomiasis, a parasitic disease affecting millions of persons in tropical and subtropical countries. He is engaged in a three-year study of the disease in Kenya.



STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION

Before the Subcommittee on Rural Development

Committee on Agriculture U.S. House of Representatives

by

Robert E. Reiheld, M.D.

Following is an excerpt from Dr. Rieheld's presentation delivered October 1, 1974. Dr Reiheld, a family practitioner in Orrville, is Chairman of the AMA's Council on Rural Health. He has also served for 16 years as a member and chairman of the Ohio State Medical Association Rural Health Committee.

THROUGH A CONTINUOUS and comprehensive program, the Council on Rural Health has worked toward the development of optimum health for rural America. Of primary concern to the AMA is the availability and utilization of health services and facilities in rural areas, including increased availability of health manpower, community involvement in health planning, consumer health education and rural health research.

The problem of rural health care is a diverse and broadly based phenomenon, the solution of which will require participation of many different organizations and agencies at the local areas, and on the national level. Coordination of these efforts is needed to assure that these efforts are channeled toward common goals. One of the most significant activities on the AMA in this respect is its liaison with national farm, educational, research, informational, and allied health organizations. To facilitate this liaison, the Council on Rural Health has an Advisory Committee with representation from 14 national organizations:

American Agricultural Editors' Association

American Bankers Association

American Dental Association

American Farm Bureau Federation

American Nurses' Association, Inc.

American Public Health Association

American Veterinary Medical Association

Cooperative Extension Service

Farm Foundation

National Association of Farm Broadcasters

National Extension Homemakers Council

National Grange

National Safety Council

Woman's Auxiliary to the AMA

The two basic health care problems of rural areas are medical manpower and organization of services. Adequate medical manpower facilitates the task of developing the organization of medical care in rural areas, and an established group practice can make recruitment and retention of physician manpower easier to accomplish. Organized medicine has taken an active role in matching physicians seeking practice areas with localities requesting assistance in obtaining a physician. All state medical associations, with the exception of New Jersey, have a Physicians' Placement Service which both physicians and communities may utilize. In addition, the AMA has a Physicians' Placement Service.

It is certain that many small communities that once had their "own" physician will never again have one. It has become clear that, for some rural areas, solutions completely different from the traditional "physician in residence" must be sought. In many areas, emphasis may be needed on expanded transportation and communication capabilities, use of new allied health professionals, better understanding of individual health practices, and development of emergency care and self-help methods to ensure rural health coverage. Multiple communities, in a logical service area, will need to plan together to develop health care systems on an area basis so as to attract appropriate health manpower working in a group to provide home, clinic, and hospital care. Planning for health services on an area basis makes it necessary to examine access to medical care in terms of time needed to reach a care center rather than just distance from a physician. Planning must also recognize divergent needs for health services requiring new types of health workers, technology, and emergency care practices.

Part of the AMA's recommendations to assist rural areas to develop health care systems is found in the Rural Health Care Delivery Improvement bill — proposed by the AMA and introduced in both houses of Congress in October, 1973. This bill would create an Office of Rural Health within HEW. The Rural Health Office could award

grants, contracts, loans, and loan guarantees to examine existing models of rural health delivery, determine their applicability and transferability elsewhere, and develop and demonstrate new models which incorporate some or all of these activities:

- 1) Selection of rural area and delineation of health services
- 2) Use of beneficial health components
- 3) Use of transportation

professionals

- 4) Use of communications technology
- 5) Use of biomonitoring technology
- 6) Development of emergency medical services
- 7) Inclusion of health and nutrition education
- 8) Provision of continuing education for health
- 9) Utilization of community health planning
- 10) Securing of community support
- 11) Use of appropriate dental services

Another integral part of a rural health care system is the development of an emergency medical services program in the area. With the limited medical manpower available in many rural areas, plans for an emergency medical services program are very crucial. The Emergency Medical Services Systems Act of 1973 will encourage area initiative to improve these services by providing that not less than 20% of the grants and contracts funded under the Act will be for systems serving rural areas. The American Medical Association has given strong support to this measure, which is

essentially similar to a bill that the AMA had developed.

Considerable study has been given to alternative methods for alleviating maldistribution of health manpower. Approaches currently under consideration or trial involve both attempts to relocate physicians and other health workers, and to develop alternative methods for ensuring availability of health services when needed. One resource available to help areas where health services are inadequate because of critical shortage of health personnel is the National Health Service Corps (NHSC).

Our Association has worked closely with the Corps to make the program a functioning reality. We have carried out information campaigns to the profession, to state and local medical societies and, since 1972, have contracted with the Corps to recruit private physicians to replace the Corps physicians on a short-term basis. This program, which we have named PROJECT U.S.A., has been a valuable adjunct to the Corps in operating the program. Physician acceptance of PROJECT U.S.A. has been overwhelming. The number of physician volunteers has far exceeded the number of available vacancies. Since March, 1973, when we began placing these physicians, more than fifty have served in these areas of critical need. The Association will continue to promote the National Health Service Corps and to work with the Corps' Regional Program Directors.

(Continued on Page 46)

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(Continued)

The growth and development of family practice programs in medical schools are also noteworthy. Since 1969, eighty-one of the four-year medical schools have established such training programs. An outstanding feature in many of these programs is preceptorships or clerkships for family medicine in a community setting. In addition, approved family-practice residency programs have now reached 220, and the number of residency positions projected for July, 1975 is 3.800.

Legislatures of many states, particularly those with a large rural population, have financially backed the expanded training of family practitioners. They fully realize that the more of these physcians that there are, the greater will be the pool available for location in rural areas. All recruitment for rural areas must be seen as a twosided consideration. Not only must the student be adequately prepared for rural practice, the rural area must be adequately prepared for the graduated student. A basic preparation that communities must make is to think and plan in terms of planning jointly with other communities and seeking two or more doctors, at least, rather than one. As the experience of the National Health Service

Corps has persuasively demonstrated, two doctors are easier to retain than either of them would be alone. Two doctors mean a helpful peer relationship. They mean that one physician has the opportunity for continuing education, other activities, and leisure while the other renders needed health care

Mr. Chairman, I can sum up my remarks by saving that doctors are aware of the need for better and more accessible health care in rural localities. Together with other groups and organizations, we are actively developing new approaches to the problems. Experience indicates that no one approach will solve the health needs of every community, but solutions can be tailored as required.

Floyd D. Loop, M.D., of Cleveland Clinic's Department of Thoracic and Cardiovascular Surgery, and Samuel Kaplan, M.D., of Cincinnati, were chosen to participate in a recent cardiovascular disease lecture tour of Latin America. The tour was one of a series co-sponsored by the U.S. Department of State and the American College of Cardiology.

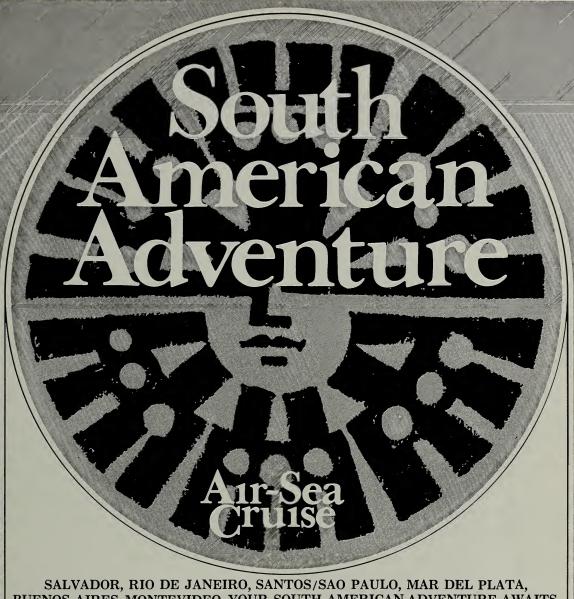


DESCRIPTION: Methyltestosterone is 178-Hydroxy-17-Methylandrost-4-en-3-one. ACTIONS: Methyltestosterone is an oil soluble androgenic hormone. INDICATIONS: In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. PRECAUTIONS: Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. CONTRAINDICATIONS: Contraindicated in persons with known or suspected cardinoma of the prostate ard in cardinoma of the male breast. Contraindicated in the presence of severe liver damage. WARNINGS: if priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or preocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. ADVERSE REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia may result in the patients with metastatic breast carcinoma. This usua

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START THE NEW YEAR OFF RIGHT!

Even though the deadline for submission of Resolutions for the 1975 Ohio State Medical Association Annual Meeting is not until March 12, it's not too early to make your first New Year's Resolution. Resolve to attend the 1975 OSMA Annual Meeting, May 11-14, in Columbus. Check page 50 for hotel room reservation form.

THE THEME FOR THE MEETING WILL BE "OUR MEDI-CINE IS GOOD: LET'S MAKE IT BETTER."

The following schedule will be of interest to any person representing his county in House of Delegate work. All association members are welcome to attend the House of Delegates meetings.

Sunday, May 11

First Session of House, Sheraton-Columbus Hotel
3:00 - 7:00 p.m. Registration for OSMA House
of Delegates
4:00 p.m. Councilor District Caucuses
5:30 p.m. Buffet Dinner for Delegates,
Alternates, OSMA Council
and Official Guests
7:00 p.m. OSMA House of Delegates
First Business Session

Monday, May 12

8:30 a.m Noon	Reference Committee Hear-
	ings, Sheraton-Columbus Hotel
	Resolutions Committee No. 1
	Resolutions Committee No. 2
	Resolutions Committee No. 3
	President's Address
	Committee on Nominations
1:30 p.m.	Continuation of Reference Committee Hearings

Wednesday, May 14

Final Session of H	ouse, Sheraton-Columbus Hotel
2:30 - 3:30 p.m.	Registration of Delegates, Alternates, OSMA Council and Official Guests for the Final Session.
3:30 p.m.	OSMA House of Delegates Final Business Session
6:00 p.m.	Buffet Dinner for Delegates, Alternates, OSMA Council and Official Guests
6:45 p.m.	Continuation of Final Session, House of Delegates

All exhibits will be at the Veterans Memorial Building, 300 West Broad Street. Exhibits will be open Monday, May 12, 12:00 Noon to 4:00 p.m.; Tuesday, May 13, 9:00 a.m. to 4:00 p.m.; and Wednesday, May 14, 9:00 a.m. to 3:00 p.m.

Scientific programming will start Monday afternoon, May 12, at Veterans Memorial Building and continue through Tuesday and Wednesday, May 13 and 14.

Scientific programs are coming in now and the first one to reach our office before press time is the program sponsored by the OSMA Section on Allergy and the Ohio Society of Allergy and Immunology to be held Wednesday afternoon, May 14, starting at 1:30 p.m. The entire program is printed for your convenience.

PROGRAM

Presiding:	James I. Tennenbaum, M.D., Columbus, Chairman, Sec- tion on Allergy
1:30 p.m.	Non Allergic Causes of Wheezing in Children — Joseph M. Mattimore, M.D., Clinical Assistant Professor of Pediatric, State University N.Y. at Buffalo. nued on Next Page)

(Continued) 2:00 p.m.

Rehabilitation of Asthmatic Children Joseph E. Ghory, M.D., Clinical Professor of Pediatrics, University of Cincinnati College of Medicine and Medical Director, Convalescent Hospital for Children, Cincinnati.

2:30 p.m.

The Autonomic Nervous System and Asthma — D. Duane Hauser, M.D., Director of Immunology Education Service, Methodist Hospital, Indianapolis, Indiana.

3:00 p.m.

Question and Answer Period Doctors Mattimore, Ghory and Hauser.

3:00 p.m.

Business meeting of the Ohio Society of Allergy and Immunology.

This is just a sampling of one of the many scientific programs sponsored by scientific sections and specialty society groups. In addition to these programs there will be postgraduate courses offered on Tuesday, and continued Wednesday, on the following subjects: Blood Gases; Acid Base Disturbances; Principles of E. K. G.; Chemotherapy of Infections: Bacterial, Viral, Fungus; Vascular Diseases — Venous and Arterial; Ischemic Heart Disease; Immunology Principles; Cancer: Treatment and Diagnosis; Emergency Room Medicine; Sexual Counseling; Endoscopy of the GI Tract: Diagnostic and Therapeutic; Chronic Lung Disease; Radioactive Isotopes: Advances in diagnosis using radiology, ultrasound, isotopes; Cardio-pulmonary Resuscitation and Low Back Pain. The Journal will carry more information about these programs in later issues and a special mailing will be sent to all members.



Following are names of new members of the Ohio State Medical Association certified to the headquarters office during November 1974. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

CUYAHOGA (Cleveland) SCIOTO Leonico Y. Carlin William E. Forsythe, III Hai Lee Lin Annie J. Lumanlan Felino P. Reyes, Jr. Troadio D. Terrado

LORAIN Liengkong Siew Elyria

LUCAS (Toledo) Michael J. Gordon Jose Salazar

MONTGOMERY (Dayton) David J. Cavanaugh Michael E. Hamilton Rudolf A. Hofmann

Wei Shun Cheng Portsmouth David B. Hanzel Wheelersburg Bom Sae Lee Portsmouth Ting L. Liu Wheelersburg Kathryn F. Skitarelic Portsmouth

STARK Krishna P. Agarwala Canton Thomas P. Berg Massillon

Srirama P. Chalasani Canton Choonghee C. Lee

Alliance Mahendra K. Thakkar Alliance



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Doubles			\$29.00-\$32.00-\$35.00
Studio		 	\$29.00-\$35.00
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NEIL HOUSE MOTOR HOTEL

41 South High Street (OSMA Overflow Hotel)

Singles	\$18.00-\$20.00-\$22.00
Doubles	\$24.00-\$26.00-\$28.00
Twins	\$26.00-\$28.00-\$30.00-\$32.00
Parlor and 1 Bedroom	\$50.00-\$55.00-\$60.00
Parlor and 2 Bedrooms	\$70.00-\$75.00-\$140.00

SOUTHERN HOTEL

South High and East Main Streets

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Doubles	\$18.00-\$22.00
Twins	. \$19.00-\$24.00

CHRISTOPHER INN 300 East Broad Street (Woman's Auxiliary Headquarters)

Singles	18.00-\$25.00
Doubles	\$23.00
Studio Twin	\$26.00
Studio Double	
Suites	48.00-\$65.00

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Please reserve the following accommodations of Meeting, May 11-14, 1975 (or for period indicate by April 19, 1975.	uring the p d). Note: In	eriod of the Ohio State Medic order to accommodate you, pl	cal Association Annual ease make reservations
Single Room			Twin Room
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Woman's Auxiliary Highlights

Mrs. S. L. Meltzer, Communications Chairman 2442 Dorman Drive, Portsmouth 45662

A New Year — A New Emphasis — Communications

From Paradise Lost comes this quotation: "Good, the more communicated, more abundant grows." Communications has a top priority in auxiliary activities these days for the very reason that Milton noted — to make more abundant, more productive, the good that we can do among ourselves and in our communities. For only by communicating more effectively can we hope to better accomplish our many important goals. If we are to serve the medical profession to the utmost of our abilities, we must identify the problems in communicating fully on every level of auxiliary activity and seek the solutions.

That is just what the Woman's Auxiliary to the American Medical Association set out to do a few months ago with its four regional workshops throughout the country. I was privileged to attend that of the North Central Region in Oak Brook, Illinois (just outside Chicago). The workshop on Communications was expertly chaired by Mrs. Malachi W. Sloan, II, a national director and communications chairman, and Mrs. J. Paul Sauvageot, editor of MD'S WIFE, our national magazine. (In case there should be someone who doesn't know, both are from Ohio and both have served as state president). There were also workshops on Health Education, Legislation, Membership, AMA-ERF, Community Health and Family Health.

There was a broad spectrum of discussion and exchange of ideas and suggestions re/communications — the necessity for being understood — the recognition that communications is a two-way street with people relating to each other — the necessity for follow-up procedures, for education, for good public relations. Five areas for improved communications were cited: within the auxiliary itself; with physicians' organizations; with the individual communities; with other health-oriented organizations; and with the newspaper, radio and television media. Specific problems were aired such as lack of feedback from the counties, apathy, poor public relations with the medical society, poor relations with the media, lack of recognition in the community, irrelevant programs, lack of knowledge about auxiliary aims and projects, inability to project ideas to other groups and poor planning.

On the positive side, the twelve chairmen representing the North Central Regional States highlighted outstanding individual auxiliary projects that were a big plus for communications. Mrs. Sloan and Mrs. Sauvageot dealt with a number of "specifics that should prove of inestimable help for each state's communications program.

That New Statute

From Mrs. Albert May, state legislation chairman, comes this important message: "Recently I had the opportunity to attend a seminar on 'Estate Planning' offered by the American Professional Practice Association. It was chaired by Edward Annis, M.D. a past president of the AMA. A considerable amount of time was devoted to the 'Employee Retirement Income Security Act of 1974' which was signed into law by President Ford on Labor Day. This legislation is the most comprehensive, involved and complex statute ever enacted dealing with private pension and profitsharing plans For a real in-depth explanation of the new law, I would like to recommend the booklet 'Concise Explanation of the Pension Reform Law' published by Prentice-Hall, Inc., Englewood Cliffs, New Jersey 07632. The cost of the booklet is \$1.25. One of the Conference participants stressed that this booklet should be made available to the accountant handling our husbands' financial matters."

Here and There

Montgomery county auxiliary swung into legislative action back in October when it held an 11 a.m. "Punch Bowl and Informal Reception" at Neil's Heritage House to enable its members to meet and talk with the candidates running for election. A noon luncheon followed at which the guest speaker was David L. Rader, director of the legislative department of OSMA. Mr. Rader discussed "A Look Into The Future." There was even a nursery provided at the nearby Southern Hills United Methodist Church to make possible a really big attendance of the younger mothers!

(Continued on Next Page)

(Continued)

Scioto county auxiliary played hostess recently to the wives of doctors from neighboring counties in Ohio, Kentucky and West Virginia who were attending the annual Medical Seminar presented by the Scioto County Medical Society. There was a luncheon at Harold's Restaurant and a program featuring unusual Christmas decorations and gifts by Mrs. George Taylor, manager of Mercy Hospital's Gift Gallery. The group's November meeting was a luncheon and tour at the new Shawnee Mental Health Center in Portsmouth, to which members of the Bar Association auxiliary were also invited.

Stark county auxiliary is really "communicating"! Its members served on a board of review in December for the Salvation Army to help make the decisions as to the eligibility of applicants for Christmas jobs. Some of the membership also gave two weeks' typing services. There was also much activity in International Health — the making of johnny coats out of donated white or pastel men's shirts — the packing, in October, of 1,000 pounds of drug samples, and another such packing session held in November at Molly Stark Hospital. Old eyeglasses were also sought to send on to World Medical Relief in Detroit. Stark county's November meeting was a luncheon at Higbee's Everhard Room to which attorneys' wives were invited. Mrs. Ralph Regula spoke on "One Foot In Washington." And the December meeting was a Holiday Brunch at the Imperial House with the Rev. Dr. George Parkinson delivering the Christmas Message. Each member brought a toy for a girl or boy under twelve years of age to be given to the children of underprivileged families. Another community service rendered by the Stark county group was helping at the Christmas Seal building with the posting, filing and counting of money.

> "Thine own wish, wish we thee" for this New Year!

Industries In Akron Plan Alcohol Treatment Consortium Covering 50,000 Workers

Major industries in Akron, have agreed to form a consortium in order to support a city-wide occupational alcoholism staff, reports the National Clearinghouse for Alcohol Information.

The consortium, representing about 50,000 employees, would work to put alcoholism treatment in the mainstream of community health care, according to Edward J. Canarie, executive director for the American Association Against Addiction (AAAA) in Akron.

First suggested and coordinated through the AAAA, the proposed consortium would develop a staff to train supervisors to recognize job deterioration and early signs of alcoholism. Another staff function would be identifying employee illnesses, including alcoholism, and possibly managing some form of outpatient treatment for alcoholism.

So far, the consortium program is still in the planning stages, with funding arrangements yet to be finalized, Mr. Canarie said.

Dr. Jean Jones Perdue, Association board president said organizing industries or community services to deal collectively with alcohol problems has been AAAA's principal focus since philanthropist and tire manufacturer, the late Harvey S. Firestone, Jr., started the association 6 years ago.

Ohio ranked seventh last year for the amount received from the Veterans Administration for facilities, operations, and benefits for veterans and dependents. The Administration granted the state of Ohio \$577.6 million in 1974. California received the highest amount, and Alaska, with only 41,000 veterans, received the lowest amount for any state.



Is He a Source of Information?

Yes, with certain reservations. The average sales representative has a great fund of information about the drug products he is responsible for. He is usually able to answer most questions fully and intelligently. He can also supply reprints of articles that contain a great deal of information. Here. too, I exercise some caution. I usually accept most of the statements and opinions that I find in the papers and studies which come from the larger teaching facilities. It goes without saying that a physician should also rely on other sources for his information on pharmacology.

Training of Sales Representatives

Ideally, a candidate for the position as a sales representative of a pharmaceutical company should be a graduate pharmacist who has a questioning mind. I don't think this is possible in every case, and so it becomes the responsibility

of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce - information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone

in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

capacity they are indeed useful; particularly in the fact that they disseminate broadly based educational material and serve not just as "pushers" of their drugs.

The Other Side of the Coin

Obviously, the pharmaceutical companies are not producing all this material as a labor of love they are in the business of selling products for profit. In this regard the ambitious and improperly motivated sales representative can exert a negative influence on the practicing physician, both by presenting a one-sided picture of his product, and by encouraging the practitioner to depend too heavily on drugs for his total therapy. In these ways, the salesman has often distorted objective reality and undermined his potential role as an educator.

The Industry Responsibility

Since the detail man must be an information resource as well as a representative of his particular pharmaceutical company, he should be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—i.e., the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that informa-

tion must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

Pharmaceutical Manufacturers Association 1155 Fifteenth Street, N.W. Washington, D.C. 20005



A Half Century of Health Progress

By Harry Schwartz, Ph.D.*

Visiting Professor of Medical Economics Columbia University, New York City

INEVITABLY WHENEVER WE CELEBRATE a major anniversary for any institution the temptation arises to look back. What were things like in the beginning and what are they like now? These are reasonable questions, and I thought I'd raise them to mark the present celebration. What was the health of the American people like a half century ago, and what it is now? Of course, then as now all human beings are mortal. All of us will die, but what are our chances of living longer than our ancestors—and perhaps more to the point what are the chances of our children and grand-children living longer?

The answer, of course, is that the chances are excellent because there has been fantastic medical progress over the past half century. Yet one of the problems of public discussion today is the fact that this progress is often overlooked in consideration of medical policy. If one took literally all the nonsense about the supposed "health crisis" which is ladled out by the ton over the major communications media one might think that the health of the American people had deteriorated seriously this past half century. But this is obviously and emphatically not true. Let us look at the facts, therefore, and I apologize in advance for the circumstance that most of these facts are statistical in nature. I think it was Lord Kelvin who once said that unless you could count, your knowledge was meager and unsatisfactory. In the area of health we can do a great deal of counting.

Health is obviously a multidimensional phenomenon and it cannot be measured by any one number. But perhaps the nearest approximation of that number is the life expectancy of a child born in a given year. The reason is that this figure is really the average age of death of all persons who have died in a particular year. Viewed either way, this is an important indicator. In 1920 that expectation was 54.1 years. In 1973, on the other hand, the expectation of life at birth was 71.3. Put another way, in little more than 50 years—and more personally, within the period of my life time—life expectancy at birth has risen more than 17 years, almost one-third in fact. That would seem to be a major achievement.

*Dr. Schwartz is the author of *The Case For American Medicine* (New York: David McKay Co. 1972). This article first appeared in the *Cleveland Physician*, September 1974.

Up to date life expectancy figures by sex and color are, unfortunately, not available. But we can look at death rates to get some idea of what has happened. In 1920 the overall average death rate was 13.0 per thousand population. In 1973 it was 9.4. The indicated decline is about 25 per cent, but that understates the case, of course, because of the aging of the population. On an age-adjusted basis the death rate has declined more than 50 per cent.

But our major interest is looking at the great groups of our society, men and women, white and non-white. In 1920, whites as a group had a death rate of 12.6; in 1973 the same figure was 9.5, a decline of slightly less than 25 per cent. Non-white death rates went from 17.7 to 9.2 in the same period, a fall of almost 50 per cent. It would seem impressive.

What about the male-female differences receiving so much attention these days? The data are so set up that we cannot compare male death rates and female death rates as we did white and non-white rates. But if we are willing to combine sex and color criteria we can make some instructive and even awe-inspiring comparisons.

In 1920, for example, the death rate of non-white females was 17.5 per thousand population. In 1973 the corresponding figure is 7.6. The indicated decline of almost 60 per cent is surely a major achievement. White females have done well, too. They have gone from 12.1 deaths per thousand population in 1920 to 8.3 in 1973. The decline is about 30 per cent, only roughly half that for non-white females but itself no mean accomplishment.

If we turn to non-white males, now, we find their comparable decline in death rates was from 17.8 in 1920 to 10.9 in 1973. The indicated decline in death rate is a very substantial 40 per cent, a percentage less than that registered by the nonwhite female death rate but greater than the improvement registered by white females. Finally we turn to white males where the achievement, though still significant, is percentagewise the least. The white male death rate fell from 13.0 in 1920 to 10.7 in 1973. This decline is only about 20 per cent. If we ignore the effect of age changes we have to conclude that medical progress has contributed most dramatically to the decline of nonwhite female death rates this past half century and least dramatically to the decline of white male

death rates. I don't suppose that one person in a thousand selected at random would guess that there had been this dramatic a decline in death rates and that the beneficiaries among major groups had gained differentially in the curious and perhaps unexpected pattern the data recited above reveal.

As a white male, myself, I think high priority needs to be given to learning why males as a group do so much more poorly than females, and why white males have done poorest of all by the criteria we have just been examining.

What about infant mortality? All of us have heard the reproachful charges that the United States is 58th or 17th or whatever in the world infant mortality rate sweepstakes. The usual conclusion offered by these sweepstakers is that American medicine has failed abysmally in its debt to our babies. The actual data, however, show quite the contrary to be true. In few areas, actually, has progress been so sensational.

The facts are plain enough. In 1920 the infant mortality rate in the United States was 85.8 deaths per thousand live births. Only two years earlier, in 1918, the rate had been 100.9, i.e. more than one baby of every 10 born died in the first year of life. In 1973 the infant mortality rate was 17.6, i.e. roughly speaking only one baby out of each 60 born that year died before it reached the age of one. The decline in infant mortality rate beween 1920 and 1973 was almost 80 per cent. There are cynics, of course, who argue that we now have legalized abortion because doctors have helped make being born so safe. If the overwhelming majority of babies being born are going to survive, these cynics argue, artificial means such as legalized abortion have to be resorted to to help contain the population explosion.

It is an unfortunate fact that the infant mortality rate of non-whites is significantly higher than that of whites, a reflection primarily of the poverty and social pathology that besets so many nonwhites. Nevertheless both white and non-white babies have gained enormously from the progress of the past half century. In 1920, the infant mortality rate among white babies was 82.1; last year it was 15.2, a decline of more than 80 per cent. In 1920 the infant mortality rate of nonwhite babies was 131.7 deaths per thousand live births, i.e. more than one-eighth of all non-white babies born failed to reach their first birthdays. Last year the non-white infant mortality rate was 28.8, or almost 80 per cent less than in 1920. True, much more needs to be done to lower the non-white infant mortality rate to the white level, but the strides already taken have been gigantic.

Many factors have contributed to this impressive record of progress against death. Increasing prosperity and the improved living conditions it has brought about are certainly important. So

is the great shift from rural to urban residence with all that implies in improved medical care, better provision of safe water and the like. Not negligible, of course, are the great advances in medicine, particularly the discovery and mass introduction of the antibiotics and sulfa drugs which did so much to reduce the tolls of infectious diseases. The polio vaccine was perhaps the most dramatic advance, and polio, a disease which caused dread to millions every year is now almost unknown. Other vaccines, for measles, whooping cough and diphtheria for example, have also contributed much.

It is worth looking, therefore, at the impact of these advances as reflected in the steeply declining death rates of some of the most common and important infectious diseases as of 1920. Below we compare the 1920 and 1973 death rates of these diseases:

Cause of death	d	eath rate	es per
		100,000	pop.
		1920	1973
Tuberculosis		113.1	1.8
Syphilis		16.5	0.2
Enteritis and other diarrheal	disease	53.7	1.1
Whooping cough		12.5	0.0
Influenza & pneumonia		207.3	29.1
Measles		8.8	0.0

These and other similar gains are certainly impressive. But all of us die sooner or later. So what the great advances in health have done is to give us, on the average, substantially longer lives, and when we die now we tend to die most usually of some degenerative disease of old age. Here for example is a group of causes of death which are now exacting larger tolls of human life than they did in 1920.

	death ra	tes per
Cause of death	100,00	00 pop.
	1920	1973
Cardiovascular and renal diseases	364.9	501.0
Cancer*	83.4	151.8
Cirrhosis of the liver	7.1	16.0
Motor vehicle accidents	10.3	26.5
*Excludes cancer of the lymphat	ic and	blood-
forming tissues		

The accomplishments of modern medicine and public health and the impact of better living standards have been little short of phenomenal this past half century. That they are valued so little these days is testimony to the ignorance of some critics and to the fact that for all of us yesterday's miracle is today's routine. I can remember very well when the introduction of the first antibiotic drugs produced a world sensation. Today most of the discussion centers on the alleged abuse and overuse of antibiotics. The price of success, I suppose, is to be taken for granted. That has happened in medicine, but it is a proud record nevertheless.

Obituaries

Lloyd A. Boehm, M.D., Toledo; Ohio State University College of Medicine, 1940; aged 64; died November 17; member of OSMA and AMA.

William Henry Charlebois, M.D., Youngstown; New York Medical College, 1955; aged 51; died November 23; member of OSMA and AMA.

Floyd Milton Elliott, M.D., Ada; Loyola University Stritch School of Medicine, 1925; aged 83; died November 8; member of OSMA and AMA.

DeWitt Clinton Lavender, M.D., Mansfield; Ohio State University College of Medicine, 1912; aged 84; died November 12; member of OSMA and AMA.

James E. McCormick, M.D., Zanesville; Ohio State University College of Medicine, 1933; aged 69; died November 13; member of OSMA and AMA.

Alden Bayard Oakes, M.D., Portsmouth; State University of New York, Downstate Medical Center, 1940; aged 60; died November 7; member of OSMA and AMA.

George A. Palmer, M.D., Akron; University of Michigan Medical School, 1929; Aged 72; died November 25; member of OSMA and AMA.

Paul Troup, M.D., Dayton; University of Cincinnati, College of Medicine, 1936; aged 68; died November 6; member of OSMA and AMA.

Samuel Hugh Williamson, M.D., Springdale; Western Reserve University School of Medicine, 1920; aged 81; died November 17; member of OSMA.

Edgar H. White, M.D., Seminole, Florida; Northwestern University Medical School; 1936; aged 64; died October 1; member of OSMA and AMA.

Dr. Lester A. Ballard, Jr. has been named Head of the Department of Gynecology at the Cleveland Clinic. The appointment was anannounced by Dr. James S. Krieger who has relinquished the position of department head, but will continue as an active member of the department and as Chariman of the Clinic's Division of Surgery.

Dr. Ballard received his M.D. degree at Ohio State University, School of Medicine. He received specialty training at Case Western Reserve University Hospitals, and joined the Clinic Staff in 1966.

The quinquennial meeting of the United States Pharmacopeial Convention will be held March 22 at the Statler Hilton Hotel in Washington, D.C. Individual practitioners and students are welcome to attend the meeting as observers.

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1975 Annual Meeting, Ohio State Medical Association

O YOU HAVE AN EXHIBIT or know of an exhibit which is of scientific interest? If you do, the Ohio State Medical Association Annual Meeting is just the place to display it. We are now accepting applications for the 1975 OSMA Annual Meeting. Those eligible to apply are as follows: (1) Exhibits by Ohio physicians, Ohio medical schools, hospitals or similar organizations; (2) Out-of-state physicians or out-of-state agencies on invitation; (3) Voluntary health organizations.

Exhibits will be set up and viewed at the Veterans Memorial Building, 300 West Broad Street, Columbus, Ohio. Exhibit Days and Times will be as follows: Monday, May 12 — 12:00 Noon - 4:00 P.M.; Tuesday, May 13 — 9:00 A.M. - 4:00 P.M.; and

Wednesday, May 14 — 9:00 A.M. - 3:00 P.M.

Mail applications to the attention of J. E. Tetirick, M.D., Chairman, Committee on Scientific Work, Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215.

APPLICATION FOR SPACE SCIENTIFIC EXHIBITS

1975 Annual Meeting, Ohio State Medical Association

Veterans Memorial Building, Columbus, May 12, 13 and 14

l am interested in receiving an appli exhibit at the 1975 OSMA Annual Mee	cation and details regarding space for a scientific eting. Please send to:
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In This Issue:

Allen's Coin Shops28
The Brown Pharmaceutical Co., Inc13, 40, 46
Burroughs Wellcome Co43, 55
Capital Financial Services45
Flint Laboratories, Div. of Travenol Lab., Inc
Geigy Pharmaceuticals53, 54
International Travel Advisors, Inc47

Lilly, Eli and Company14
McNeil Laboratories3
Mead Johnson Laboratories21
The Medical Protective Company60
Menendian, K. A. Carpets8
Ohio Medical Indemnity24
Pharmaceutical Manufacturers Association56, 57
Roche Laboratories, Div. of Hoffman- LaRoche, Inc , 6, 7, 34, 35, Inside Front Cover, Inside Back Cover, Back Cover
Roerig & Co., Div., Pfizer9
Searle Laboratories, Division of G. D. Searle & Co
SK&F Co., Subsidiary of Smith, Kline & French Laboratories
University Center62
Wendt-Bristol Co
Windsor Hospital49

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> ARNOLD H. KAMBLY, M.D. Psychiatrist-Director

The third annual Spring Meeting of the American College of Surgeons will be held April 21-24 at the Hyatt Regency Atlanta and Marriott Motor Hotel in Atlanta, Ga. The main purpose of the meeting will be postgraduate education, with special emphasis on eight formal postgraduate courses. William V. Nick, M.D., Columbus, is chairman for the course titled "Current Applications of Computers for Surgeons."

The American Society of Contemporary Medicine and Surgery will hold its Tenth Annual Meeting and Scientific Assembly March 2-7 at the Americana Hotel, Bal Harbour, Fla.

The New Hampshire Historical Society is currently sponsoring a project to edit the papers of Josiah Bartlett (1729-1795). Josiah Bartlett, a signer of the Declaration of Independence, was a prominent physician in New England and the founder of the New Hampshire Medical Society. Persons having knowledge of the existence of correspondence to or from Bartlett or of other papers written or signed by him are requested to contact the Historical Society at Thirty Park Street, Concord, New Hampshire 03301.

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An h.s. dose added to the b.i.d. or t.i.d. treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



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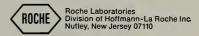
surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies.

Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or over-

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea. fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states. anxiety, hallucinations, increased muscle

spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.





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OSU Study Shows Caring For Patient's Isn't Enough

What physicians, nurses and hospital personnel say and how they act affects the health and well-being of anxious, worried hospital patients.

Caring is not enough, a study at Ohio State University shows. The study is aimed at finding out how the communication process works between

hospital staff and patients.

"A tilt of the head, a forceful gesture or look have a significance for a patient that a person functioning in an everyday situation would not even notice. The communication process is extremely important to hospital patients, because they are under stress," said Mrs. Jean Daubenmire, associate professor of nursing at Ohio State.

Mrs. Daubenmire is the director of the research project which began in 1971 with a threeyear grant of \$250,000 from the U.S. Department of Health, Education and Welfare. Thus far, researchers have completed the first phase of the

study—gathering information.

With their permission, four patients, two male and two female, were recorded on videotape by remote television cameras from the time they entered Ohio State University Hospitals to the time they left. One of the patients had terminal cancer, another was a mother who was donating a kidney to save her child's life, the third a young man who had his arm amputated in an accident and the fourth a woman who came into the hospital with the possibility of a cancer recurrence.

"All four patients had complex physiological and psychological problems. They were very helpful and consented to be part of the study," Mrs.

Daubenmire said.

Although in many cases hospital personnel cared and were concerned about the patients, they were not always successful in translating that attitude into action.

For example, one videotape segment shows a patient receiving medication from a staff member and engaging in a friendly conversation. The patient flatly states that his illness is terminal. Immediately, the staff member backs away from the bed, tries to change the subject and finally slips out of the room, leaving the patient shaking his head and talking to himself. This happened over and over again to the patient each time he told someone that he was going to die. The patient needed to talk about it, but no one wanted to

"It's not the length of time spent with the patient but the way the time is spent," Mrs. Daubenmire said. The long-term goal of the project is to provide information which would help hospital personnel become more aware of patients' needs and responses. Such awareness could relieve the patients' anxiety, fears and frustrations.

The post-T&A patient: another type for Tylenol acetaminophen products



When the post-T & A patient requires an analgesic, a new problem arises. Hemorrhagic tendencies following the use of aspirin after tonsillectomies have been reported.1.2 In a patient who "... has recently undergone a surgical procedure or has another underlying hemostatic defect, aspirin ingestion may cause significant bleeding....Aspirin is absolutely contraindicated in such situations. Acetaminophen...could replace aspirin in these instances."3

The post-T & A patient is only one of several 'types for TYLENOL' antipyretic-analgesic products—that is, patients who should avoid aspirin. Considering all of them, wouldn't it provide added safety (as well as added convenience) to recommend TYLENOL products routinely for simple analgesia?

References: 1. Reuter, S.H., and Montgomery. W.W.: Arch. Otolaryng. 80:214-217 (Aug.) 1964. 2. Osol, A., et al., ed.: The United States Dispensatory and Physicians' Pharmacology, ed. 26, Philadelphia, J.B. Lippincott Co., 1967, p. 171. 3. Schwartz, A.D., and Pearson, H.A.: J. Pediat. 78:558-560 (March) 1971.

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Continuing Education Opportunities for Physicians in Ohio

February

Physicians in Nuclear Medicine — The Nuclear Medicine Institute, Cleveland, will sponsor a 4-week continuing education course for physicians in nuclear medicine; on Feb. 17-21, March 17-21, April 14-18, May 12-16; each session is Monday through Friday; for further information, contact D. Bruce Sodee, M.D., Director, Nuclear Medicine Institute, 6760 Mayfield Rd, Cleveland, 44124.

Electromyography XV — OSU College of Medicine, Center for Continuing Medical Education, 320 W. Tenth Ave., Columbus 43210; February 17-20; fee is \$225.

Management of Ear, Nose, and Throat Disorders — Stouffer's University Inn; sponsored by OSU College of Medicine, Center for Continuing Medical Education, 320 W. Tenth Ave., Columbus 43210; February 19; fee is \$40.

Blood Bank Management — Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; Feb. 26-27.

Orthopaedic Problems — Fawcett Center for Tomorrow, 2400 Olentangy River Rd., Columbus; sponsored by OSU College of Medicine, Center for Continuing Medical Education, 320 W. Tenth Ave., Columbus 43210; February 27; fee is \$40.

Annual Infectious Disease Conference — University of Cincinnati College of Medicine, CON-MED, 234 Goodman St., Cincinnati 45229; Feb. 20.

March

Ophthalmology Symposium — Fawcett Center for Tomorrow, 2400 Olentangy River Rd., Columbus; sponsored by OSU College of Medicine, Center for Continuing Medical Education, 320 W. Tenth Ave., Columbus 43210; March 3-4; fee is \$100.

Common Post-Operative Complications: Prevention and Treatment — Hospitality Motor Inn, Middleburg Heights; sponsored by the Westshore Foundation for Medical Education; 9:00 a.m. to 5 p.m.; March 5.

Some Thoughts on Total Care of Patients with Cancer — Steubenville Country Club; Mar. 11 at 8:15 p.m.; speaker will be Arthur J. Murphy, Jr. M.D., Pittsburgh; sponsored by Fort Steuben Academy of Medicine.

Medical Progress and its Relationship to Dentistry — Cleveland Clinic Educational Foundation, 9500 Euclid Ave, Cleveland 44106; Mar. 12-13; fee is \$45.

Annual VA Hospital Symposium — University of Cincinnati College of Medicine, Office of CONMED, 234 Goodman St, Cincinnati 45229; Mar. 13.

Core Curriculum: Pediatric Echocardiography — Sponsored by the American College of Cardiology, Cincinnati, March 17-20, 1975. For details, contact: American College of Cardiology, Department of Continuing Education Programs, 9650 Rockville Pike, Bethesda, Md. 20014.

Laser Safety Short Course — University of Cincinnati College of Medicine, Office of CONMED, 234 Goodman St, Cincinnati 45229; Mar. 17-21; fee is \$325.

10th Annual Cancer Symposium — Akron City Hospital, Institute of Medical Education; Mar. 19-20; fee is \$10.

Recent Progress in Clinic Cancer — Cleveland Clinic Educational Foundation, 9500 Euclid Ave, Cleveland 44106; Mar. 19-20; fee is \$80.

General Practice Seminar — Fawcett Center for Tomorrow, 2400 Olentangy River Rd, Columbus; Mar. 22-23; fee is \$50; sponsored by OSU College of Medicine Center for Continuing Education.

Care of the Critically Ill Child — Sponsored by The Children's Medical Center and Wright State University School of Medicine; contact: Director of Medical Services, Children's Medical Center, 1735 Chapel Street, Dayton 45404; March 26; fee is \$20.

March

The Veterans Administration Hospital in Chillicothe will present accredited lectures on the following subjects during March: Neurological Conference Case Presentation, Dr. Schellhouse; EKG's — Arrythmias and Ectopic Beats; "The Frontal Lobe"; Pathological Seminar, VAH Minneapolis; Trapoblastic Disease: Dx and Tx; Clin-

(Continued on Page 73)

icopathological Conf.; Radiological Seminar; Psychiatric Seminar; Neurological Conference Case Presentation: Dr. Kumar; "History Taking—Part I"; Patient with Short Breath; Neuropathology Conference; EKG's—Metabolic, Drug and Electrolyte Changes; "History Taking—Part II"; "Psychosis in Elderly Patients"; Neurological Conference Case Presentation: Dr. Socarras; Infections and Antibiotics; "Neurological Exam—Cranial and Spinal Nerves"; "Consideration in Breast Masses"; Physician-in-Residence; "New Concepts in Restorative Dentistry."

April

Practical Neurology — Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; April 2-3; fee is \$80.

Lederle Symposium on Arthritis — Sheraton-Columbus Hotel, Columbus; co-sponsored by the Ohio Academy of Family Physicians; April 6.

Use and Abuse of Injectable Steroids — Steubenville Country Club, Annual Trauma Meeting of Fort Steuben Academy of Medicine; Robert J. Murphy, M.D. of Columbus; 8:15 p.m.; April 8.

Refresher Seminar in Pediatrics for Pediatricians — General Practitioners — Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; April 9-10; fee is \$80.

Drug Therapy — Fallsview Mental Health Center, Cuyahoga Falls; sponsored by the Association of Physicians of Ohio; G. Batizy, M.D.; April 11.

Paramedical Workshop — Ramada Inn North, Columbus; sponsored by the Ohio Academy of Family Physicians; April 12-13.

Practical Perimetry for Beginners — Holiday Inn, Columbus; sponsored by the OSU College of Medicine, Center for Continuing Medical Education, 320 W. Tenth Ave., Columbus 43210; April 14-15; fee is \$70.

Diagnostic Immunology — Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland, 44106; April 23-24; fee is \$80.

Family Relations Workshop on Family Dynamics — Salt Fork Lodge, Cambridge; sponsored by the Ohio Academy of Family Physicians; April 25-27; fee is \$50 for members and \$65 for nonmembers.

Biomechanics — Cleveland Plaza, Cleveland; sponsored by the American Academy of Ortho-

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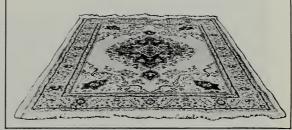
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Abdominal Surgery — UC Medical Center; contact University of Cincinnati College of Medicine, Office of CONMED, Dean's Office, 234 Goodman St., Cincinnati; April 30-May 1; fee is \$100, \$50 for residents.

May

Microneurosurgery Symposium, Cincinnati Convention Center, May 29-31, 1975. Directors: Stewart B. Dunsker, M.D., and John M. Tew, M.D. Lectures, practical demonstrations and discussions will be provided by an international faculty. Special courses for nurses and surgical assistants also will be conducted. Sponsored by the Departments of Neurosurgery, The Christ and Good Samaritan Hospital, Frank H. Mayfield,, M.D., Director. For details, write: Ms. S. Stuckey, Coordinator, Microneurosurgery Symposium, 506 Oak St., Cincinnati 45219.

The University Association for Emergency Medical Services will hold its annual meeting May 20-24 at Bayshore Inn, Vancouver, British Columbia, Canada. The fee is \$60 for MD's, and \$30 for Residents. Contact: Arthur E. Auer, Executive Secretary, P.O. Box 1241, East Lansing, Mich. 48823.

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Primary Pulmonary Hypertension and Sickle Cell Trait

Leon Yoder, D.O. Enayatollah Tabesh, M.D. James T. Taguchi, M.D.

> Medical conditions, both chronic and acute, which stimulate latent sickle cell trait into an acute disease condition.

CICKLE CELL TRAIT was once considered to O be unassociated with any untoward clinical effects. However, several reports in recent years have warned about the potentially serious and even lethal complications that may arise when certain inciting factors are present. Generally, these complications occur when factors that enhance sickling of the red cells result in increased blood viscosity with thrombosis and infarction of various organs. The following report describes the clinical course and progression of pulmonary hypertension in a patient with sickle cell trait which led to cor pulmonale and death.

Case Report

A 45-year-old Negro man was transferred from a nearby hospital to the Veterans Administration Hospital, Dayton, Ohio, on May 29, 1971, with a complaint of acute shortness of breath and chest pain of two days' duration.

The patient was first hospitalized eight years prior to this admission with severe thigh pains thought to be due to a femoral neuritis. He had a past history of pulmonary tuberculosis which had been inactive since 1965. Six years previously, he was found to be hypertensive and was treated intermittently with reserpine and diuretics. Two years later, he was found to have cirrhosis of the liver of unknown etiology but suspected secondary to chronic alcoholism. Three years prior to admission, he was treated for decompensated liver cirrhosis manifested by ascites and edema. He was also found to have iron deficiency anemia, secondary to gastrointestinal bleeding, which was treated and corrected. Electrocardiogram (ECG) made at this time showed nonspecific ST-T wave changes (Fig. 1). One year prior to admission, he was again treated for decompensated liver cirrhosis, and he also carried a diagnosis of nephrosclerosis secondary to hypertension. There were several reports of red blood cells in the urine. He was found at that time to have a systolic murmur at the left sternal border and apex. He also had an S₃ gallop, distended neck veins, besides the marked ascites and edema. An electrocardiogram revealed right axis deviation. He responded well to therapy and was discharged.

Three months later, he returned again with the same clinical picture of ascites and edema, but the murmur was recognized as being tricuspid in origin and the gallop as a right heart event. At this time the diagnosis of pulmonary heart disease was made, and it was thought to be secondary to primary pulmonary hypertension. ECG at this time showed classical right ventricular hypertrophy (Fig. 2). Pulmonary angiography showed a sharp cut-off from the primary to the secondary branches of the pulmonary artery (Fig. 3). Cardiac catheterization demonstrated angiographic evidence of tricuspid insufficiency. It also revealed a mean right atrial (RA) pressure of 22 mm Hg; right

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(Dr. Tabesh). Submitted April 19, 1974.

ventricular (RV) pressure of 100/29 mm Hg; pulmonary artery (PA) pressure of 104/45 mm Hg; capillary wedge pressure of 13 mm Hg, and left ventricular (LV) pressure of 116/17 mm Hg. The patient was treated with digitalis, diuretics, and placed on salt restriction. He improved gradually. He returned in three months and cardiac catheterization was repeated. Pulmonary artery pressures were unchanged, but right atrial and right ventricular diastolic pressures were markedly reduced with RV pressure showing only 117/7 mm Hg and RA pressure only 1 mm Hg. No cardiomegaly or tricuspid insufficiency was evident. The patient was discharged with no ascites or edema. He was maintained on digitalis, diuretics, and salt restriction.

The physical examination on the final admission revealed an asthenic Negro man who was quiet but alert and in moderate respiratory distress. His extremities were cold and pulseless. The blood pressure was unobtainable either by auscultation or palpation. The neck veins were markedly distended with prominent CV waves. Breath sounds were diminished but clear to auscultation. The precordium demonstrated a right ventricular heave and a systolic thrill. The heart rate and rhythm were regular with a grade IV out of VI holosystolic murmur heard best at the left sternal border and unchanged on respirations. There was also a loud P2 and a widely split S2. No gallops were heard. The abdomen was markedly distended with ascites and the liver was palpable, but it was not pulsatile. There was no peripheral edema.

Hospital Course

The patient was placed in the intensive care unit where a central venous pressure catheter was inserted into the external jugular vein. The initial reading was 16 cm H₂O. The blood pressure was maintained with metaraminol drip, however, the hourly urine output continued to decrease. The patient became more somnolent and dyspneic. Ten hours after admission, he went into respiratory arrest and resuscitation procedure was unsuccessful.

Autopsy Report

The heart weighed 400 grams with the right ventricle measuring up to 1 cm in thickness. Calcified granulomas were observed in both upper lung fields consistent with inactive tuberculosis. The lungs revealed presence of chronic congestion microscopically. The small pulmonary artery branches revealed medial hypertrophy, and the lumina were frequently stenosed by organizing thrombosis with active fibroblastic proliferation (Figs. 4 and 5). Sickle cells were observed within the arteriolar thrombi (Fig. 6). The bone marrow was hyperplastic, and sickling was observed in the sinusoids. The liver weighed 1,070 grams and revealed advanced micronodular cirrhosis. There was also moderate hemosiderosis in the liver. The spleen weighed 240 grams and was consistent with

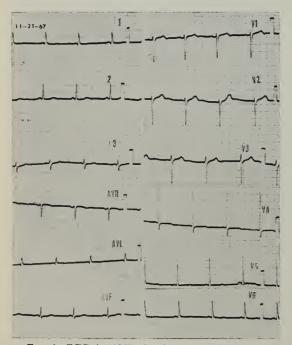


Fig. 1. ECG in 1967 showing only minor nonspecific ST changes.

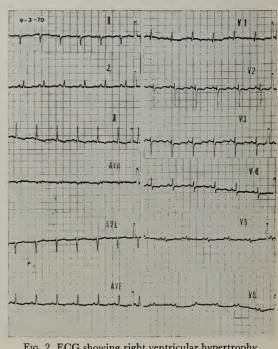


Fig. 2. ECG showing right ventricular hypertrophy.

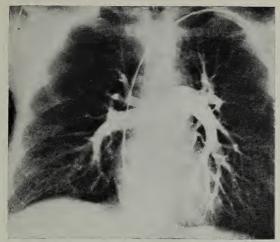


Fig. 3. Pulmonary angiogram showing dilation of main branches of pulmonary artery. Secondary branches, especially in upper parts of both lungs, are blocked or show marked narrowing.

chronic congestion. No other areas of sickling were found except those in the lung.

Discussion

Hemoglobin SA, a finding in 10 to 15 percent of American Negroes, has been found to produce disease under certain conditions. It is well known that sickling occurs with changes in oxygen tension and pH, and these changes have been observed in the laboratory. Jones and Binder reported four cases of sudden death in four healthy Army recruits who were stationed at an army base at 4,060 feet altitude. Autopsies of each showed generalized sickling. Hypoxia, lactic acidosis, and dehydration were considered factors in precipitating the sickling. Other reports where hypoxia was thought to be the inciting factor in sickling were those of a mountain climber who developed splenic



Fig. 5. Note extensive thrombosis involving nearly all pulmonary vessels with medial hypertrophy of small arteries.

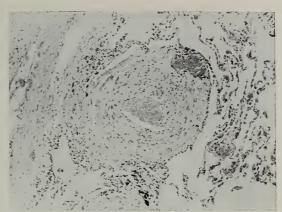


Fig. 4. High power shows marked medial hypertrophy, fibroblastic proliferation, and thrombosis.

infarctions,3 and a patient who developed acute hemolysis following bronchography.⁴ The latter patient also had G-6-PD deficiency. Acidosis was believed to have caused sickling in a patient in diabetic ketoacidosis.⁵ The autopsy report showed generalized microvascular occlusions thought to be secondary to intravascular sickling. The effects of alcohol on red blood cell morphology in patients with SC, SA, SS, and AA2 hemoglobin were investigated by Rubler, et al⁶. Nearly all of the patients with sickle cell trait showed sickling and other red cell morphology changes 120 minutes after alcohol ingesting. The principal factors postulated in the sickling were (A) the direct effect of alcohol itself on the red blood cells; (B) acetaldehyde, which is the metabolite of alcohol; (C) the acidosis produced by excessive alcohol ingestion; and (D) the combination of any of these factors.

The patient reported here had intermittent episodes of acute right heart failure. This could have been explained by recurrent episodes of intravascular thrombosis produced by sickling. The autopsy data confirms this finding by the obser-

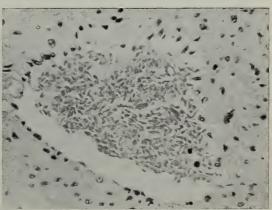


Fig. 6. Magnification demonstrates that thrombi consist of sickled cells.

vance of sickle cell thrombi in the small pulmonary arterioles. The cause of the sickling is speculative. The patient did have a history of inactive tuberculosis in which case mild hypoxia may have induced some sickling crises. The patient was also a known alcoholic, and it is reasonable to assume that this was an important factor in his sickling. Other conceivable causes of pulmonary hypertension in cirrhosis of the liver are: idiopathic changes in pulmonary vasculature, thromboemboli originating from portal venous system and/or portapulmonary and intrapulmonary arteriovenous anastomosis.⁷

Summary

A case report of primary pulmonary hypertension with right ventricular failure associated with liver cirrhosis and portal hypertension in a patient with sickle cell trait is described. It was felt that alcoholism may have been the major factor in initiation of sickling in this patient leading to multiple pulmonary emboli and pulmonary hypertension. Perhaps attention to other cases with primary pulmonary hypertension might well uncover similar relationships.

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Thyroxine Withdrawal in Thyroid Cancer

George N. Sfakianakis, M.D. Thomas G. Skillman, M.D. Jack M. George, M.D.

> The authors recommend bovine TSH stimulation of radioiodine uptake prior to either scanning or therapy as being more suitable for patient therapy than interruption of thyroxine suppressive treatment.

THE EFFICACT of the decimal of thyroid cancer with radioiodine is dependent THE EFFICACY of the treatment of metastases upon the capacity of the lesions to concentrate iodine.1-3 Thus, only follicular and papillary carcinoma can be treated and then only after stimulation of the metastases to concentrate iodine.4-7 Enhancement of iodine concentration may be achieved either by ablation of endogenous thyroxine secretion with concordant increased thyroid stimulating hormone (TSH) secretion^{1,2,4,6,7} or by admission of exogenous TSH.4,8,9 If the normal thyroid is ablated either by surgery or radioiodine, the patient will develop myxedema unless given replacement thyroxine. If subsequent doses of radioiodine are needed either to search for metastases by scanning or to treat metastases, TSH stimulation, either endogenous or exogenous, must be employed. Adequate TSH levels may be achieved either by withdrawing thyroxine for several weeks¹⁻³ or by administering bovine TSH.^{4,8,9} It has been pointed out that the advantages of increasing ¹³¹I uptake by metastases may be outweighed by the concomitant growth stimulus im-

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Dr. George, Columbus, Professor of Medicine, The Ohio State University College of Medicine. Submitted March 29, 1974.



Fig. 1. Case 1.—Photograph of patient showing facial mass and myxedematous appearance.

parted to the tumor.^{7,9} A chronic stimulation of the tumor and/or metastases by endogenous TSH has been proposed on a hypothetic basis to be a greater disadvantage than the short action of parenteral TSH administration.⁸

We report two cases of thyroid cancer in which we believe the prolonged endogenous TSH hypersecretion effected by thyroxine withdrawal was associated with a marked increase in rate of tumor growth. For this reason, we recommend that radioiodine uptake by cancer metastases be stimulated by exogenous TSH administration rather than thyroxine discontinuance.

Case Reports

Case 1.—A 66-year-old woman had a subtotal thyroidectomy at age 37 years for "multinodular goiter" and had a second subtotal thyroidectomy for recurrence of goiter at age 57 years. Microscopic study of tissue removed at the second operation disclosed "possible microfollicular changes suggestive of cancer," but no further treatment was given and the patient was lost to follow-up. When seen nine years later at age 66 years, she had a large, left facial mass in the region of the parotid gland, a mass in the thyroid bed, and an obvious pathologic fracture of the right humerus. All of the tumor masses were stony hard and fixed to surrounding tissues. Also,



Fig. 2. Case 1.—Left mandibular osteolytic lesion.

she was thought to have a myxedematous facies (Fig. 1). A biopsy showed metastatic, follicular, thyroid carcinoma. The protein-bound iodine (PBI) value was 6.0 $_{\rm ng}/100$ ml serum and 131 I uptake in the anterior neck was 10 percent at 24 hours. Her serum calcium value was 9.5 mg/100 ml and her serum phosphorus value was 2.1 mg/100 ml. The alkaline phosphatase was 16 Bodansky units (normal 1 to 4 units). Radiologic studies revealed left mandibular (Fig. 2) and right humeral (Fig. 3A) osteolytic lesions. A total-body 131 I scan (Fig. 4A) with 2 mc of 131 I, disclosed high uptake in the neck (thyroid remnant) and moderate uptake in the left face, right shoulder, left shoulder, left upper chest, left ischium, and proximal left femur. At this time, she was given an oral therapeutic dose of 200 mc of 131 I and was then followed in the clinic while taking 300 mg of desiccated thyroid daily to fully suppress endogenous TSH.

During the first four months after ¹³¹I treatment, objective decrease in volume of tumor masses was observed and the range of movement of the right shoulder improved. However, no further improvement took place during the next 11 months, and it was decided to give her a second ¹³¹I treatment. Desiccated thyroid was discontinued for four weeks, and she was admitted to the hospital. At this time, it was found that during the fourweek interval of thyroid discontinuance the facial mass has increased markedly. She complained of toothache and anesthesia of her gums and lips on the left. In addition, her left shoulder motion was more restricted and the area of osteolysis was shown on x-ray film to be 2 cm longer (Fig. 3B). A second total-body ¹³¹I scan (Fig. 4B) showed reduced uptake in the thyroid area (remnant) and greatly increased uptake in the distant metastases. The change in pattern was attributed in part to radioablation of the more iodine-avid thyroid remnant and in part to redistribution of larger quantities of the radionuclide to metastases which had been stimulated by increased endogenous TSH. The patient was given 100 mc of ¹³¹I and seven days later, the daily dose of 300 mg of desiccated thyroid was reinstituted. In a month, the facial mass returned to the size noted before discontinuation of thyroid and the complaints of toothache, anesthesia, and shoulder pain vanished. Until the present



Fig. 3. Case 1.—Humeral osteolytic lesion just before radio-ablation of the remnant (A), four weeks post-thyroxine withdrawal (B), and seven months after the second treatment (C).

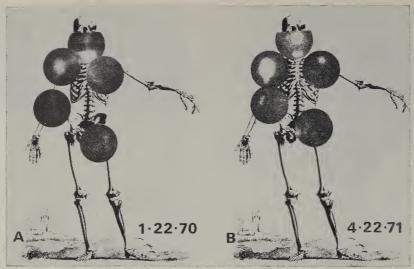


Fig. 4. Case 1.—Total body 131 I scan (Anger camera). Areas of interest superimposed on photographs of a skeleton. Before treatment (A) and after first dose of 131 I and four weeks post-thyroxine withdrawal (B).

time, both the clinical and radiographic (Fig. 3C) manifestations of the metastases have remained static.

Case 2.—A 10-year-old girl was seen 2½2 years after having undergone a subtotal thyroidectomy for papillary adenocarcinoma involving the left recurrent laryngeal nerve, trachea, esophagus, and lymph nodes on both sides of the neck. Excision of the upper portion of the right lobe could not be carried out. After surgery the patient developed hypoparathyroidism and was treated with calciferol and oral calcium as well as 0.2 mg levothyroxine per day. Postoperative therapy with 6000 rads delivered from a 60Co source was given to the cervical region. Bone and chest x-ray films (Fig. 5) showed no metastatic involvement. Serial chest x-ray films disclosed the development of miliary lung nodules (Fig. 6) which, on biopsy, were found to be follicular-papillary adenocarcinoma of the thyroid.

Physical examination on admission showed no evidence of recurrence of tumor in the neck. After four days of 10 units of bovine TSH per day, a ¹³¹I total-body

scan was made (Fig. 7A). There was an area of increased uptake in and above the thyroid remnant, and questionable accretion was found in both lungs. An oral therapeutic dose of 100 mc of ¹³¹I was given and suppressive therapy with 0.3 mg per day of levothyroxine was instituted for two months.

The patient was readmitted after the thyroxine was discontinued for four weeks to permit unsuppressed endogenous TSH to stimulate the metastatic lesions in preparation for a second dose of ¹³II. During this fourweek period, the patient developed pain in the left anterior cervical region and was found to have tender lymph nodes there. Chest roentgenograms showed no appreciable difference since the last examination. A repeat ¹³II scan (Fig. 7B) showed complete absence of uptake in the thyroid remnant but considerable increase in activity in both sides of the neck and in the lungs. Although the changes in radionuclide distribution could have been due in part to ablation of the remnant, they also were

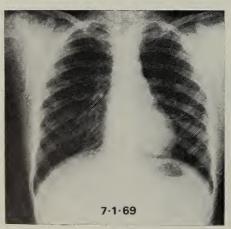


Fig. 5. Case 2.—Initial normal chest radiograph.

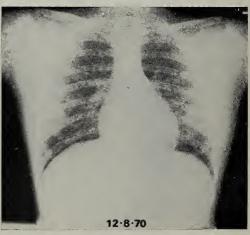


Fig. 6. Case 2.—Follow-up chest radiograph showing miliary nodules.

probably related to the clinically noted metastatic growth. During this admission 100 mc of 131I was given and, after seven days, suppression with 0.3 mg per day of levothyroxine was reinstituted. Within a month, the painful tumor masses in the neck completely regressed and subsequent chest roentgenograms have shown a decrease in the size of pulmonary nodules (Fig. 8).

Discussion

We interpret the sequence of events in these two patients as support for the hypothesis that prolonged withdrawal of thyroxine in essentially athyrotic individuals is associated with excessive endogenous TSH stimulation which, in turn, causes undesired growth of tumor and/or metastases.^{7,8} Numerous reports favor the concept that long-term suppression of TSH by thyroid feeding exercises a favorable influence in controlling TSH-responsive primary and/or metastatic thyroid cancer. 1-3,7,8,10 In our patients, surgically induced hypothyroidism (case 1) and interruption of thyroid replacement (case 2)11 probably permitted accelerated metastatic growth.

Radioiodine certainly is useful in treating such metastases, but the method of preparing the patient for treatment with large doses of ¹³¹I has not been standardized. Many centers do not discontinue thyroxine but prepare the patient for radioiodine therapy by giving bovine TSH.4,8,9 A recent report⁹ showed very high radioisotope uptake by lung metastases and a good result of radioiodine therapy using this method. Other centers favor thyroid replacement withdrawal for four to six weeks before rescanning and/or ¹³¹I treatment. ¹⁻³ In our two patients, an increased growth of metastases was noted at about the 20th day after thyroxine withdrawal. One would predict that a temporally associated significant increment of endogenous TSH was present.11,12 In patients who had undergone thyroid ablation for thyroid carcinoma, measurements of circulating TSH after withdrawal of triiodothyronine treatment or after exogenous TSH administration indicate that endogenous TSH levels after T3 withdrawal greatly exceed those achieved with exogenous polypeptide.¹² In addition, the length of time and, therefore, the total effect of TSH is doubtless much greater during withdrawal of thyroid than after TSH injection.8,12

As Levey, et al¹³ have pointed out, acute swelling of the thyroid can occur immediately after exogenous TSH administration but it is abrupt in onset, dramatic in progression, and disappears as quickly as it appears. Such enlargement is probably due to an increase in thyroid blood volume as it is accompanied by an increase in local temperature.

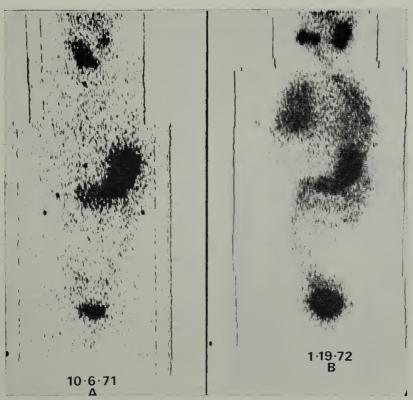


Fig. 7. Case 2.—Total body 131 I scan (rectilinear scan). Before treatment (A) and after first dose of 131 I and four weeks post-thyroxine withdrawal (B).

Our patients gradually developed moderate enlargement and tenderness of their metastatic lesions and the tumors were firm and without an increased tactile sense of temperature. Also, their mass lesions decreased in size only after a number of weeks during which thyroid replacement was reinstituted. Although we cannot prove that tumor growth was caused by thyroxine withdrawal, the circumstantial evidence is strong that this was so in these two cases.

Conclusion

The described thyroid tumor stimulation after thyroxine therapy discontinuation, based mainly on clinical observations, has been observed only infrequently. However, less pronounced but equally serious cases may be more common. We suggest that bovine TSH stimulation of radioiodine uptake prior to either scanning or therapy is more suitable than thyroxine suppressive treatment interruption. The well-known disadvantages of TSH administration^{14,15} are less important than the danger of inducing more harm while preparing the patient for ¹³¹I treatment.

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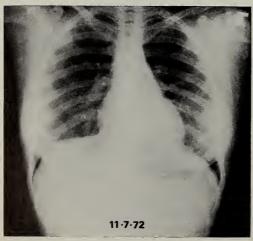


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Medical Scientific Articles

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Autologous Transfusion

Report of a 29-Month Experience in a Large General Hospital

Warren W. Smith, M.D. Patricia Michael

The procedure of preoperative withdrawal of one or two units of a patient's blood, for use in case of need of transfusion during surgery, merits much more usage than it has had. The successful, 29-month experience at Riverside Methodist Hospital, Columbus, with a program encouraging preoperative phlebotomy is reported here.

THE ADMINISTRATION OF BLOOD to appropriately cross-matched recipients has become so commonplace and standardized that it has been necessary, on occasion, to enjoin the clinician to caution against overzealous use. Nevertheless, the well-known disadvantages of such transfusion indicate that improvements as to availability, as well as safety, are still desirable. More logical than the use of blood from another individual is the use of blood from the patient himself. The first to use the patient as his own donor was Grant,1 who had a patient with polycythemia scheduled for craniotomy. Despite the logic and facility with which blood may be taken for possible later readministration to the patient, the very success of conventional blood banking during and since World War II left little stimulus for the development of alternate means. Since 1960, however, various groups have used the technic of autologous transfusion with considerable success.

In general, patients may have several phlebotomies of 500 ml each during the three weeks

Dr. Smith, Chairman, and Ms. Michael, Secretary,
 Transfusion Committee, Riverside Methodist Hospital, Columbus, Ohio.
 Submitted June 5, 1974.

prior to surgery. The blood is stored in accordance with American Association of Blood Banks (AABB) standards and is administered during or after surgery if needed. Milles, et al² reported their experience with almost 1,000 patients. The surgical procedures included thoracoplasty, pulmonary lobectomy, and various types of abdominal surgery, including hysterectomy. They concluded from this experience that a patient replaces his blood volume following a single 500-cc venesection within a matter of hours; and even after multiple venesections, the patient would come to surgery with only a slight reduction in red cell concentration and with no demonstrable impairment of his ability to withstand surgery.

Procedure and Contraindications

The Transfusion Committee of Riverside Methodist Hospital, Columbus, Ohio, contemplating the continuous problem of short supply of "bank" blood in the community (despite the support of an excellent local American Red Cross Blood Bank), decided to arrange a procedure for autologous transfusion for patients scheduled for elective surgery.

Procedure.—For the time being, no more than two phlebotomies of 450 ml for each individual patient are done. The first is performed not earlier than 15 days preoperatively, and the second approximately ten days later.

This provides two units of autologous blood, which would be used first at the time of surgery if blood was needed.

The prospective donor must (1) donate at the Riverside Methodist Hospital blood bank, and (2) have an order written by his surgeon for "phlebotomy for possible autotransfusion."

Unless otherwise arranged with the blood bank personnel, donors must be 18 years of age or older, and the amount removed each time will be no more than 450 ml.

A prospective donor undergoes the standard blooddonor health screening. At the time the patient donates blood, he is given a card to turn in at the hospital laboratory at the time of his admission to the hospital. This will alert the blood bank to the presence of unit(s) of autologous blood for that patient. Further, when the patient is admitted to the hospital, a prominent sticker will be placed on his chart cover indicating that autologous blood is available for him.

Following successful completion of the patient's surgery, if the blood was not used, and after the release by the patient's surgeon, the blood, if acceptable by current AABB criteria, then would be available to supplement regular supplies.

Contraindications.—The procedure is not indicated for the following:

- 1. Anemia (hemoglobin value less than 11.5 gm/ml.)
- 2. Ischemic cardiovascular or cerebrovascular disease.
- 3. Patients with known or suspected malignant disease, unless special circumstances are present.

Autologous blood may be administered without a formal cross-match procedure. Units of blood taken for subsequent possible autotransfusion will be identified by donor name, address, and Social Security number.

Summary

This procedure went into effect January 1, 1972. It was given wide publicity before the surgical staff and the general public. Our experience during the first 29 months has been most gratify-

ing. A total of 102* patients were accepted for phlebotomy prior to surgery. Fourteen additional patients,† all scheduled for total hip replacement, had blood drawn many *months* prior to surgery and frozen by the local American Red Cross Blood Bank. This blood was later thawed preoperatively and held for use on the operative day.

Twenty-six surgeons have used this facility during the first 29 months. The types of cases for which autologous blood was drawn and used included lumbar laminectomy (five), total hip replacement (13), hysterectomy (11), mammoplasty (21), cholecystectomy (five), and others.

No adverse effects attended either the drawing of the blood for transfusion or the subsequent readministration of that blood.

In our experience, an autologous blood transfusion program is one whose logic immediately commends itself to the attending staff of any hospital. This program can be implemented easily, can significantly relieve the limited supply of available blood, and can reduce the complications of blood transfusions from donors other than the patient.

*As of December 4, 1974, this experience amounted to a total of 136 patients.

†As of December 4, 1974, there were 18 additional patients.

References

- 1. Grant FC: Autotransfusions. Ann Surg 74:253-254, 1921.
- Milles G, Langston HT, Dalessandro W: Autologous Transfusion. Springfield, Ill, Thomas, 1971.

Free Booklet Explains Federal X-Ray Standard

A reference booklet on the Federal diagnostic x-ray equipment standard is available from the Food and Drug Administration's Bureau of Radiological Health. The 10-page booklet, "A Practitioner's Guide to the Diagnostic X-Ray Equipment Standard," was prepared primarily with the needs of x-ray users and owners in mind. But others working in the healing arts who are not directly involved with the clinical use of x-ray may also find it useful.

The pamphlet highlights major provisions of the standard and summarizes what practitioners need to know to meet their responsibilities. The x-ray equipment standard, which became effective August 1, 1974, was issued by FDA under authority of the Radiation Control for Health and Safety Act to reduce unnecessary patient exposure during diagnostic x-ray examinations.

Single free copies of the Practitioner's Guide are available from the Bureau of Radiological Health (HFX-25), 5600 Fishers Lane, Rockville, Md. 20852. Multiple copies may be purchased from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402 for 40¢ per single copy. Orders of 100 or more copies receive a 25 percent discount. Stock number 1715-00075 should be used in ordering from GPO.

AMA to Launch Regional Continuing Education Program

The American Medical Association's new program of regional continuing education for physicians will be launched next month with meetings in Florida, Arizona, Minnesota and Virginia.

The purpose of the program, to be conducted by the AMA's Council on Scientific Assembly, is to take AMA continuing education courses to physicians throughout the country. The regional programs are an outgrowth of the successful continuing education courses presented at recent AMA annual and clinical conventions.

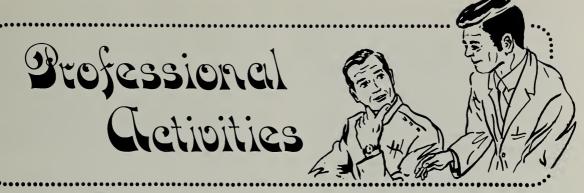
The courses will be held on weekends, enabling physicians in each region to attend at the lowest possible cost in time and travel expenses. Active support from state medical associations will be sought in each region.

Each regional program in 1975 will include eight courses, with faculty drawn largely from nearby medical schools. All courses will qualify for the highest category of continuing education credit. The courses are: Dermatology for Non-Dermatologists; Infectious Diseases and Antibiotics; Basic and Advanced Life Support-Cardiopulmonary Resuscitation; Fluid and Electrolyte Balance; Venereal Disease; Pulmonary Function and Blood Gases; Basic Electrocardiography; and Human Sexuality.

Seven of the courses will last six hours and be presented twice on each program, enabling doctors to take two courses. The session on cardiopulmonary resuscitation (reviving heart attack victims) is a 12-hour course.

The regional courses will be offered in Tampa, Fla., Feb. 8-9; Phoenix, Ariz., March 15-16; Minneapolis, Minn., July 26-27; and Williamsburg, Va., September 27-28.

Further information on the courses is available from the Department of Scientific Assembly, American Medical Association, 535 N. Dearborn St., Chicago, Ill. 60610.



Proceedings of The Council

Meeting of December 14-15, 1974

REGULAR MEETING of the Council of the Ohio State Medical Association was held Saturday and Sunday, December 14 and 15, 1974, at the Columbus Headquarters' office, 600 S. High Street, Columbus, Ohio.

Those present Saturday were: All members of The Council; Mr. James E. Pohlman, Esq., Columbus, OSMA Legal Counsel; Richard L. Meiling, M.D., Columbus, Chairman of the Ohio Delegation to the AMA; H. William Porterfield, M.D., Columbus, representing OMPAC and OFMC; and Messrs. Page, Edgar, Campbell, Clinger, Rader, Houser, Holcomb, Mulgrew, Mrs. Wisse, Mrs. Dodson and Mrs. Tanner, of the OSMA Staff.

Those present Sunday were: All members of The Council; Mr. Pohlman, J. Richard Costin, D.O., representing the Ohio Osteopathic Association of Physicians and Surgeons, and all members of the OSMA Staff (with the exception of Mr. Houser and Mrs. Tanner).

The meeting was called to order by President Henry.

The minutes of the October 26-27, 1974 meeting of the Council were approved.

Membership

Mrs. Wisse announced that both OSMA and AMA figures for Ohio on December 2nd showed a substantial gain over the same date in 1973. It was pointed out that the Ohio State Medical Association membership is already over the membership as at December 31st of last year.

Fiscal Matters

The Council was convened in executive session to consider the budget for 1975. At the close of the executive session, the Council was reconvened in regular session and by official action the report of the Committee on Auditing and Appropriations and the 1975 budget were approved.

American Medical Association

Dr. Meiling reported on the Clinical Session of the American Medical Association held in Portland, Oregon, November 30-December 4, 1974.

OSMA Annual Meeting

Progress report on the 1975 Annual Meeting and the exhibits was presented by Mrs. Dodson and was accepted.

A letter from one of the Specialty Society groups, requesting that the fee for guest speakers be increased, was presented to the Council. It was the Council's opinion that the fee presently paid by the Ohio State Medical Association for Annual Meeting speakers is in line with what other state medical societies are paying, and with present budget restrictions, it is difficult to make a change at this time.

MAI/Peer Review Systems

Dr. Oscar W. Clarke reported on Medical Advances Institute activities and developments since the last meeting of the Council.

Ohio Medical Indemnity

Dr. Robert G. Thomas reported on the December 11th meeting of the Board of Directors of Ohio Medical Indemnity, Inc. The report was accepted for information.

Ohio Foundation for Medical Care

Mr. Campbell reviewed the minutes of the Board Meetings of the Ohio Foundation for Medical Care held November 6, 1974 and December 11, 1974.

Dr. H. William Porterfield, President of the Ohio Foundation for Medical Care, presented the annual report of the Foundation. He also announced that on March 9th, there would be an educational program on Foundation activities and on the role of the Ohio Foundation for Medical Care.

Committee Reports

Committee on Public Relations

Mr. Edgar discussed the Medix series of television documentaries which has been produced by the Los Angeles County Medical Association and which has been offered to the Ohio State Medical Association by the Burroughs Wellcome Company (Continued on Next Page)

for selected television stations on a noncommercial public service basis. The Council approved the recommendation of the Committee on Public Relations, that the Ohio State Medical Association cosponsor this series and further that county medical societies in the areas where the programs will be aired be encouraged to co-sponsor the program.

Commission on Medical Education

The minutes of the Commission on Medical Education for October 30, 1974, were presented by Mr. Edgar. The Committee recommended a reduction in the proposed application fee for the Physicians' Recognition Program and for a reduction in the proposed accreditation fees for certifying institutions who wish to become a continuing medical education facility.

The Council accepted the reductions on a temporary basis with the request that these fees be reevaluated after six months of operation. The remainder of the report was accepted for information.

Committee on Prisons and Jails

The minutes of the November 13th meeting of the Committee on Prisons and Jails were presented by Mr. Houser. The Council discussed the mission of the Committee. The report was accepted for information.

Committee on Health Care of the Poor

The minutes of the November 6th meeting of the Committee on Health Care of the Poor were presented by Mr. Houser and were accepted.

Committee on Health Manpower

The minutes of the Committee on Health Manpower for the meeting of November 14, 1974, were presented by Mr. Clinger. It was indicated in the minutes that legislation involving physicians' assistants had been adopted by the Committee for the consideration of the Council. The minutes were accepted for information.

Committee on Mental Health

The minutes of the Committee on Mental Health for the meeting of December 8, 1974, were presented by Mr. Clinger. The Council reaffirmed its approval of the recommendation for "establishment of a rotating advisory committee (from the Committee on Mental Health) to assist in cases involving physicians who find their professional status threatened by mental health problems involving alcoholism and drug dependence."

Recommendations concerning the directorship of the Department of Mental Health and Mental Retardation were received for advice and consideration. The Council approved the Committee's recommendation that the OSMA, the Ohio State Pharmaceutical Association, the Ohio Board of Pharmacy, the Ohio Hospital Association, and other interested organizations pool their talents to survey what has already been accomplished throughout Ohio in the control of drug abuse. Consideration could then be given to selecting a

small Ohio community for a pilot project involving an experimental system of prescription control. The Council agreed with the Committee that further consideration of legislation or other state-wide programs in prescription control be postponed until the results of the pilot program are received and analyzed.

Policy Regarding Role of Psychologists

The Council developed and adopted the following policy with regard to the role of psychologists:

"The Ohio State Medical Association is opposed to any policy by which a psychologist may admit or discharge patients from Ohio hospitals.

"The Ohio State Medical Association opposes the treatment of hospitalized patients by a psychologist without proper consultation with a licensed physician.

"The Ohio State Medical Association believes that such practices are in violation of Section 4732.20 of the Ohio Revised Code which states '. . . in order to make provision for the diagnosis and treatment of medical problems, a licensed psychologist engaging in psychological psychotherapy with clients shall maintain a consultative relationship with a physician licensed to practice medicine by this state.'

"Furthermore, the Ohio State Medical Association believes that the practices of admitting, discharging, or treating hospitalized patients by psychologists without proper consultation with a licensed physician are in violation of the Hospital Accreditation Program established by the Joint Commission on Accreditation of Hospitals."

The Council, upon recommendation of the Committee, approved the Alcoholism Consultation and Education Program for Physicians, Nurses, and other hospital-based personnel in Ohio as sponsored by the Ohio Hospital Association.

Council Fee Review Committee

The minutes of the December 13th meeting of the Council Fee Review Committee were presented by Mr. Campbell.

There were seven cases: Case No. 1-recommendations of the Committee approved (Dr. Pichette voted "Nay"). Case No. 2 approved. Case No. 3 approved. Case No. 4 approved (Dr. Pichette voted "Nay"). Case No. 5 Council voted to change the recommendations of the Committee on a 6-5 vote. Case No. 6 approved (Dr. Pichette voted "Nay"). Case No. 7 approved (Dr. Pichette voted "Nay").

Ohio Medical Political Action Committee

Dr. H. William Porterfield, Chairman of the Ohio Medical Political Action Committee, presented a report to the Council with regard to the activities of the Committee during the past year. He also reviewed the meeting of the Board of Directors of the Ohio Medical Political Action Committee for November 19, 1974.

Councilor Reports

Councilors reported on the activities in their districts.

State Legislation

Messrs. Rader and Mulgrew presented the following proposals for consideration of the Council:

Statement on Chiropractic

The following statement on chiropractic was amended and approved by the Council (Dr. Pichette voted "Nay"):

"Chiropractors disagree among themselves on the definition of chiropractic. One group, known as the "straights," adheres basically to a rigid definition, holding that the sole route to restoration of health, no matter what the problem, is through manual manipulation of the spine. A second group, known as the "mixers," advocates the use of such modalities as heat, light, water, electricity, vitamins, colonic irrigation and other physician and mechanical adjuncts, in addition to spinal adjustments. The "mixers" also claim to be competent to do differential diagnosis utilizing medical diagnostic testing. Each group is represented by a national organization and each national organization has sub-groups within the State of Ohio.

"The chiropractic concept of disease is unsupported by scientific facts, and causes of infections and other diseases cannot be explained by chiropractors. Chiropractic theory is that disease is caused by a "subluxation" (partial dislocation) in the spinal column. Many chiropractors claim to be able to cure everything from headache to cancer by spinal manipulation—although scientific research has proved their claims impossible.

"In regard to education, a study by the Department of Health, Education and Welfare notes '. . . irrespective of its theory, the scope and quality of chiropractic education do not prepare the practitioner to make an adequate diagnosis and provide appropriate treatment.'

"Fifty states impose license limitations on chiropractic, prohibiting chiropractors from prescribing drugs and performing surgery. The Ohio State Medical Association supports current Ohio legislation which places definite limitations on the scope of practice of chiropractors in Ohio and supports the theory that, in order to protect the public health, chiropractic, if permitted to practice at all, should continue to be licensed under the Ohio State Medical Board as are all other limited practitioners.

"The scientific community, including but not limited to the medical profession, regards chiropractic as unscientific, the largest group of unscientific practitioners in the United States. "The Ohio State Medical Association has emphasized repeatedly that chiropractic is unscientific and that its practitioners lack the training and background to diagnose and treat human disease. Chiropractic is **not** a practice of medicine and constitutes a hazard to health in the United States because of the substandard and unscientific education of its practitioners and their rigid adherence to an irrational, unscientific approach to disease causation. A patient who relies on chiropractic may delay proper medical care until serious and irreversible damage occurs.

"The Ohio State Medical Association strongly disapproves of the payment of Medicaid, Medicare, Workmen's Compensation, Veterans Administration and other funds to chiropractors."

Medical Practice Act

A draft for the comprehensive revision of the Ohio Medical Practice Act was presented to the Council. The Council authorized the staff to seek comments from members, organizations, and agencies, concerning the proposal.

Health Manpower Bill (to register Physicians Assistants)

The Council requested the staff to develop a section forbidding advertising and to amend the proposal to make certain that the Certificate for the Physicians Assistant was in the physical possession of the physician employer. With these exceptions the draft received the approval of the Council.

Repeal of Prenatal Gonorrhea Test

Legislative draft was received by the Council. The repeal procedure has been mandated by the House of Delegates.

Definition of Death Proposal

A proposal with regard to the definition of death was accepted by the Council.

Constitution and Bylaws Amendments

Amendments to the Constitution and Bylaws of the Mahoning County Medical Society were approved.

Legal Counsel Report

Legal Counsel reported on the case of Gotsis v. Lorain County Medical Society. He also discussed recent hearings on proposed rules relating to chiropractors and other limited practitioners, held on December 4, by the Ohio State Medical Board and the testimony presented by him and by Dr. Paul H. Curtiss, Jr. Legal Counsel also reported to the Council on the professional liability situation and the possibilities of discussing with the Supreme Court the matter of the judicial regulation of contingent fees. Mr. Pohlman also discussed changes to improve the effectiveness of arbitration as an alternative to litigation of professional liability disputes. (Continued)

Field Service Report

Mr. Holcomb presented a report for the Department of Field Service. He indicated that since the service was organized, he has made 35 visits to county medical societies.

The Ohio State Medical Journal

Dr. Meiling, Consulting Medical Editor, requested provisions whereby the review of questionable manuscripts could be accomplished by obtaining the services of an expert in the field covered by the manuscript. He asked for authority to select such consulting editors to review manuscripts on request at an established fee, in return for a written report. This concept was approved by the Council, contingent upon review by Legal Counsel.

Mrs. Tanner reported that she is investigating an offset printing process for the printing of The Journal and that the campaign to obtain additional advertising is underway.

National Health Service Corps

Requests for approval of National Health Service Corps health manpower services were received from the Brown County Medical Society, the Mahoning County Medical Society and the Putnam County Medical Society.

Such documents contained the approval of each county medical society for these services and asked that the OSMA endorse these actions. Council voted endorsement of the requests of these societies.

School of Osteopathic Medicine Proposed

Dr. Richard Costin, past-president of the Ohio Osteopathic Association of Physicians and Surgeons, addressed the Council concerning a proposal to create an Ohio College of Osteopathic Medicine, and to make an appropriation of state funds for this purpose. The Council accepted the information and voted that the proposal be placed under study.

Licensing of Interns and Residents

The staff was asked to discuss with the Medical Board, the Ohio Hospital Association and county medical societies' presidents, the matter of interns and residents being properly licensed. It was pointed out that "moon-lighting" outside the confines of the training institution under the temporary certificate provided for under Section 4731.291 of the Ohio Revised Code is illegal, and that any physicians in training must have a full-fledged license in Ohio to practice anywhere outside the training institution. It was also pointed out that he is required to practice only under the supervision of the attending medical staff of the hospital or facility when he is a holder of a temporary certificate.

Adjourned.

ATTEST: Hart F. Page
Executive Director

IMPORTANT INFORMATION: This is a Schedule V substance by Federal law; diphenoxylate HCI is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCI) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCI may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCI and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, glant urticaria and paralytic lleus.

edema, glant urticaria and paralytic lleus.

Dosage and administration: Lomotil is contraindicated in children less than 2 years old. Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCI with 0.025 mg. of atropine sulfate. Liquid, 2.5 mg. of diphenoxylate HCI and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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OSU Chairman Elected To Head Miss Wheelchair America 1975

Miss Wheelchair America, a national contest honoring young handicapped women, will be headed in 1975 by Ernest W. Johnson, M.D., Columbus. Dr. Johnson is Professor and Chairman, Department of Physical Medicine and Rehabilitation, College of Medicine, The Ohio State University Hospitals.

A non-profit organization, Miss Wheelchair America is designed to recognize the continued commitment of one woman in furthering the goals of the physically impaired. Contestants are selected on a state by state and major city basis. The women are judged on personality, accomplishment in spite of their handicaps, and ability to communicate the goals of the physically impaired to the public. A major goal has been to eliminate the architectural barriers that prevent the handicapped from participating in society. At least forty contestants are expected to take part in this year's

Miss Wheelchair America was begun by Dr. Phillip Wood, one of Dr. Johnson's faculty members, and has since developed into an annual pageant. Dr. Johnson who has been involved in a supportive role since the contest's inception, was elected president for the upcoming year.

A leader in continuing efforts to assist the handicapped population, Dr. Johnson has been instrumental in such projects as "Creative Living" (which provides independent, barrier-free housing for young, severely disabled individuals in Columbus) and the Ohio Wheelchair Athletic Associa-

Anyone interested in supporting Miss Wheelchair America, or desiring further information, can contact: Miss Wheelchair America Pageant, Inc., 472 West 8th Avenue, Columbus 43210.

Hearing impaired persons in Southwestern Ohio are now able to watch subtitled 11 p.m. news on KMUB-TV, Oxford and WOET-TV, Kettering. The public television version of ABC Evening News with Harry Reasoner and Howard K. Smith is identical to the 6 p.m. network version with the exception that commercials have been deleted.

The concept was developed by public television station WGBH-TV in Boston. Funding is through a grant from the office of Health, Education and Welfare.

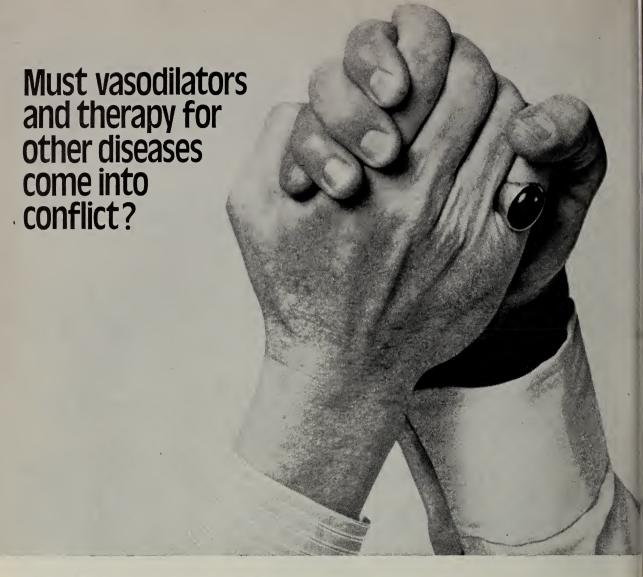


DESCRIPTION: Methyltestosterone is 178-Hydroxy-17-Methylandrost-4-en-3-one. ACTIONS: Methyltestosterone is an oil soluble androgenic hormone. INDICATIONS: In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. PRECAUTIONS: Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. CONTRAINDICATIONS: Contraindicated in persons with known or suspected cardinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. WARNINGS: if praipsim or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased ejaculatory volume • Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. ADVERSE REACTIONS: Cholestatic junidice • Oligospermia and decrease seguitation of the progression of bone metastases • Sodium and water retention • Priapism • Virilization in female

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The cerebral or peripheral vascular disease patient often has coexisting disease¹ which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

- For the relief of symptoms associated with cerebral vascular insufficiency.
- 2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
- 3. Threatened abortion.

 $Final\ classification\ of\ the\ less-than-effective\ indications\ requires$ further investigation.

Composition: Vasodilan tablets, isoxsuprine HCI, 10 mg. and 20 mg. Dosage and Administration: 10 to 20 mg. three or four times daily. Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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Meddini LABORATORIES

Policy On Psychologists Approved By OSMA Council

Recommendations from the Ohio State Medical Association Committee on Mental Health for a firm policy on the possible illegal practice of medicine by psychologists have been adopted by the Council.

The Committee on Mental Health, under the leadership of Milton M. Parker, M.D., Columbus, developed the recommendations following reports that many psychologists in many parts of Ohio have hospital staff privileges. The Committee also reported that psychologists were attempting to secure admission privileges at state mental health facilities through the legislative process.

The new OSMA policy is as follows:

"The Ohio State Medical Association is opposed to any policy by which a psychologist may admit or discharge patients from Ohio hospitals.

"The Ohio State Medical Association opposes the treatment of hospitalized patients by a psychologist without proper consultation with a licensed physician.

"The Ohio State Medical Association believes that such practices are in violation of Section 4732.20 of the Ohio Revised Code which states '... in order to make provision for the diagnosis and treatment of medical problems, a licensed psychologist engaging in psychological psychotherapy with clients shall maintain a consultative relationship with a physician licensed to practice medicine by this state.'

"Furthermore, the Ohio State Medical Association believes that the practices of admitting, discharging, or treating hospitalized patients by psychologists without proper consultation with a licensed physician are in violation of the Hospital Accreditation Program established by the Joint Commission on Accreditation of Hospitals."

In addition to the policy on psychologists, the Council also approved the following recommendations made by the Committee on Mental Health:

1. That OSMA establish a rotating advisory committee (from the membership of the Committee on Mental Health) to offer assistance on a voluntary basis to Ohio physicians who find their professional status threatened by mental health problems including alcoholism and drug dependence.

2. That OSMA endorse the Alcoholism Consultation and Education Program for physicians, nurses and other hospital-based personnel in Ohio as sponsored by the Ohio Hospital Association.

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nicotinic acid therapy

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Nicotinic Acid100 mg.	N
Niacinamide 75 mg.	N
Ascorbic Acid150 mg.	Α
Thiamine HCL (B-1) 25 mg.	T
Riboflavin (B-2) 2 mg.	R
Pyridoxine HCL (B-6) 10 mg.	P
DOSE: 1 to 5 tablets daily.	D
AVAILABLE: Bottles of 100, 500,	Ā
1000	ï

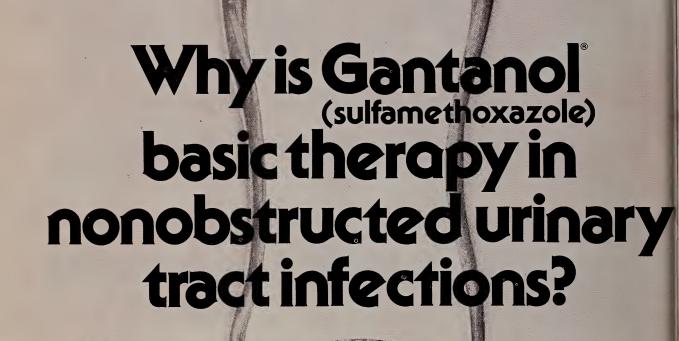
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Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient. Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur. Contraindications: Patients with known didosyncray to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute, recurrent or chronic nonobstructed urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms. Note:

Carefully coordinate in vitro sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides, especially in chronic or recurrent urinary tract infections. Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

Warnings: Safety during pregnancy has not been established.

Sulfonamides should not be used for group A beta-hemolytic strep-

tococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: Blood dyscrasias (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, pur-

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Basic Therapy Gantanol (sulfamethoxazole)

Tablets/Suspension (0.5 Gm) (0.5 Gm/teasp.)

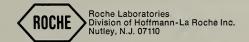
pura, hypoprothrombinemia and methemoglobinemia); allergic reactions (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); gastrointestinal reactions (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); CNS reactions (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); miscellaneous reactions (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis).

Usual adult dosage: 2 Gm (4 tabs or teasp.) initially, then 1 Gm b.i.d. or t.i.d. depending on severity of infection.

Usual child's dosage: 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs b.i.d. Maximum dose should not exceed 75 mg/kg/24 hrs.

Supplied: Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.





National Health Policy, Planning, and Resources Development Act 1974

"We cannot accept without challenge the dangerous intrusion of the federal government into the practice of medicine which this new law threatens," said Richard E. Palmer, M.D., chairman of the AMA's Board of Trustees, on January 13. "We expressed our opinions to the Congress and to the President and neither chose to heed our warnings. The courts are our last resort to prevent saddling the nation's patients and physicians with this bad legislaton." Therefore, the AMA will sue, asking court to block the planning law.

The National Health Policy, Planning, and Resources Development Act became law last month. Referring to the act, Congressman Staggers (W. Va.) said "the investment of one billion dollars during the next three years in effective planning and development of our system is a small price to pay for making high quality services available both before and after the enactment of National Health Insurance to all of our people." (Congressional Record, Dec. 13, 1974, H11821)

The Congressional Record also states that the act will revise and extend Regional Medical Program, Hill Burton, and Experimental Services Delivery Systems," combining the best features of existing programs into a single new system of area-wide health planning and resources development."

• The **principal** feature of the new law is the establishment of a National Council for Health Policy, which will coordinate:

1) Areawide health systems agencies

2) State health planning and development agencies.

The National Council for Health Policy will consist of 15 members, appointed by the Secretary of Health, Education, and Welfare for six-year terms. The council's members will include the Chief Medical Director of the Veterans Administration; the Assistant Secretary for Health and Environment, Department of Defense; and the Assistant Secretary for Health of HEW. Not less than four of the remaining 12 members shall be non-providers of health services. Not more than five members of the council shall be from the same political party.

• The governor of each state will be asked to designate Health Service Areas (HSA), subject to the approval of the Secretary of HEW. (Each area should encompass a population of 500,000 to three million.)

The Secretary of HEW, with the governor's approval, will designate a private, non-profit corporation for each health service area responsible for health planning. The corporation will have:

One director and a staff of not less than five professionals

2) A governing body of not less than 10 nor more than 30

3) An executive committee of 25.

• The Secretary of HEW will designate an agency of each state's government (chosen by the governor) as the state Health Planning and Development Agency (sec. 1421 of the act). The state Health Planning and Development Agency will create, then be advised by, a Statewide Health Coordinating Council (SHCC.) Two-thirds of SHCC's members will be appointed by the non-profit corporations responsible for planning in each health service area. Furthermore, the majority of SHCC's members must be consumers. A state-wide "certificate of need" program is also mandated.

Voting Record of Ohio Congressmen on HR16204 (which provided the legislative procedure for the National Health Policy, Planning, and Resources Development Act, 1974.)

FOR

Ashley Brown Harsha Havs Mosher Seiberling Stokes Vanik Whalen Wylie

AGAINST

Ashbrook Devine Latta Miller Regula

NOT VOTING

Carnev Clancy Guyer Luken Minshall Powell Stanton, William Stanton, James

Congress (both House and Senate) passed a HEALTH MANPOWER BILL. Senator Kennedy is said to have been instrumental in preventing the joint conference committee from accepting the Health Manpower Bill of 1974. (HR17084 and S3585).

Anticipate that Senator Kennedy will have introduced in late January a new more liberal "Health Manpower Bill" for 1975.

Anticipate Senator Kennedy will have also introduced in January a new National Health Insurance Act using the Health Manpower Act, the "National Health Policy, Planning and Resources Development Act of 1974" as well as HMO, PSRO, etc. as conjoint legislation in the health field of our country.

Provisions in OSMA Bylaws Pertaining to Nomination of President-Elect

Attention is called to provisions in the Bylaws of the Ohio State Medical Association pertaining to the nomination and election of the President-Elect at the OSMA Annual Meeting. The President-Elect and other officers are elected by the House of Delegates, meetings of which will be held during the Annual Meeting in Columbus, May 11-14.

Nominations of the President-Elect are to be made 60 days in advance of the meeting at which election takes place and information on nominations published in The Journal, unless these provisions are waived by a two-thirds vote of the House of Delegates. The 60-day deadline is March

The part of the OSMA Bylaws pertaining to this procedure is Chapter 5, Section 3, entitled "Nomination of President-Elect."

"Nominations for the office of President-Elect shall be made from the floor of the House of Delegates; provided, however, that only those candidates may be nominated whose names have been filed with the Executive Director at the time and in the manner hereinafter provided, unless compliance with such requirements shall be waived as hereinafter provided. The name of a candidate for the office of President-Elect must be filed with the Executive Director of the Association at least sixty (60) days prior to the meeting of the House of Delegates at which the election is to take place. Promptly upon the filing of such candidate's name, the Executive Director shall prepare and transmit this information to each member of the House of Delegates. No nomination for President-Elect may be presented at any meeting of the House unless the foregoing requirements of filing and transmittal have been complied with or unless such compliance shall have been waived or dispensed with by a vote of at least two-thirds (2/3) of the delegates present at the opening session of such meeting. The Executive Director shall cause to be published in The Journal in advance of such meeting of the House of Delegates biographical information on all candidates meeting the requirements of filing and transmittal."

In December, 1974, the State of Ohio Medical Board licensed 22 Doctors of Medicine and 28 foreign medical graduates.



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Antipyretic for children

- No salicylate side effects
- Store without refrigeration
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- Available only by prescription
- Grooved for one-half suppository administration

Description: NEOPAP SUPPRETTES are available for rectal administration in potencies of 2 gr or 5 gr of acetaminophen in NEOCERA® Base (a unique blend of water-soluble Carbowaxes*).

Indications: For management of fever associated with common childhood infections.

Contraindications: Sensitivity to acetaminophen or the suppository base.

Warnings: Not for use in children under three years of age. Should not be administered repeatedly to patients with pulmonary, cardiac, renal, or hepatic disease.

Precautions: Prolonged administration may result in such withdrawal symptoms as restlessness and excitement when the drug is discontinued.

Adverse Reactions: No significant adverse reactions have been reported with NEOPAP (acetaminophen) SUPPRETTES. However, adverse reactions associated with administration (usually chronic) of this drug have included the following:

Blood: Cyanosis, methemoglobinemia, sulfhemoglobinemia, and hemolytic anemia; neutropenia, leukopenia, and pancytopenia.

Allergic: Skin eruptions, urticaria, fever.

Other: Hypoglycemia, CNS stimulation, jaundice.

Dosage and Administration: Children 3 to 6 years of age: One 2 gr suppository rectally 3 or 4 times daily; not to exceed 8 grains per day.

Children 6 to 12 years of age: One 5 gr suppository rectally 3 or 4 times daily; not to exceed 20 grains per day.

*Trademark Union Carbide.



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Gov. Rhodes Appoints Two Physicians to Direct Ohio Dept's of Public Health, Mental Hygiene

Governor James A. Rhodes has appointed two highly qualified physicians to direct two departments of state government that are of particular importance to Ohio physicians. Both appointments were endorsed by the Ohio State Medical Association.

Governor Rhodes named John H. Ackerman, M.D., M.P.H., 50, to the office of Director of the Ohio Department of Public Health, and Timothy B. Moritz, M.D., 38, to the office of Director of the Ohio Department of Mental Hygiene.

Dr. Ackerman was chief of the Division of Preventive Medicine, Ohio Department of Public Health.



John H. Ackerman, M.D., M.P.H.

A native of Fond du Lac, Wisconsin and a graduate of the Marquette University College of Medicine, he was in the family practice of medicine in Iowa for five years before obtaining his Master of Public Health Degree from Johns Hopkins University in 1955. A diplomate of the American Board of Preventive Medicine, Dr. Ackerman served as a public health physician in various venereal disease centers in Florida and Georgia. He subsequently served as a consultant for the National Communicable Disease Center, Department of Health, Education and Welfare Region V, which includes Ohio. He later held various offices in the National Communicable Disease Center, Atlanta, Georgia. He has served as coordinator of the Liberian National Medical Center Project, and as a communicable disease consultant to the governments of Thailand, India, and Nigeria.

Dr. Ackerman, a member of the Ohio State Medical Association, and the Academy of Medicine of Columbus and Franklin County, is a clinical assistant professor in the Department of Preventive Medicine at the Ohio State University College of Medicine. He is a fellow of the American College of Preventive Medicine, the Royal Society of Health and the American Public Health Association.

He has had special training in the United States Navy's atomic medicine training program, the Industrial College of the Armed Forces and the American Management Association.

Dr. and Mrs. Ackerman are the parents of four children.

Appointed director of the Department of Mental Hygiene, Dr. Moritz returns to his native Ohio from Pomona, New York, where he was director of community mental health, mental retardation and alcoholism services for the Rockland County Mental Health Center.



Timothy B. Moritz, M.D.

Born in Portsmouth, he obtained his premedical degree from the Ohio State University and his medical degree from Cornell University. He took his psychiatric residency at the Payne Whitney Clinic, Cornell University—New York Hospital Medical Center, New York City, where he served as chief resident in psychiatry.

Following his residency, he served as a special assistant to the associate director for patient care, National Institute of Mental Health. He subsequently served as assistant director for hospital

services and acting associate director for adult services at the Rockland County Center, before accepting Governor Rhodes' appointment.

He is certified in psychiatry by the American Board of Psychiatry and Neurology. He was a mental health consultant for Region III of the U.S. Department of Health, Education and Welfare, and an assistant attending psychiatrist at the Payne Whitney Clinic. His many professional memberships include the American Medical Association, New York State Medical Association and the American Psychiatric Association. He also is a member of Phi Beta Kappa, Alpha Omega Alpha and the National Association for the Advancement of Colored People.

OSMA President James L. Henry, M.D., stated, "The Association heartily commends Governor Rhodes for his appointment of two exceptionally qualified and capable physicians to positions of high importance and considerable interest to physicians in particular and the residents of Ohio in general.

"The Association extends to Dr. Moritz and Dr. Ackerman our cooperation and support. Effective teamwork between the private and public sectors of medicine can assure progress for the health of Ohioans."

Name New State Directors of Insurance and Welfare

Two newly appointed directors in Governor Rhodes' administration are Harry V. Jump, Director of Insurance, and Denver L. White, Director of Welfare.

Before assuming his new position, Jump was clerk of the Ohio Senate from 1971 through 1974. He served as Deputy Director of Insurance during Governor Rhodes' previous administration. A graduate of Bluffton College, Jump was a state senator from 1967-1968.

White was also a member of Governor Rhodes' previous administration, acting as Director of Welfare from January 1963 to September 1970. He then became an administrator for the Rehabilitation Services Commission, remaining in this position until January 1974, when he retired after 34 years of service to the state of Ohio. A graduate of Ohio University, White was also the Director of Athens County Welfare Department for 15 years.



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The anguish associated with cancer is compounded by the cancer quack. False hopes—harmful delays—shattering expenses—deceptive diagnoses—loss of life—these are hazards facing the cancer patient desperate enough to seek a cancer quack.

The problem: how to divert the patient from this tragic encounter.

As medical guide, family counselor, trusted friend—you, doctor, play a major role in the fight against cancer quackery.

We are here to "partner" you.

Our National Office maintains an up-to-date central clearing house for materials on unproven methods of cancer diagnosis and treatment. This is a unique operation and the principal source of such information in the

country. Its services are widely used. Hundreds of inquiries are received and answered from all segments of the community, from coast to coast.

To trigger grass-roots action, we have formulated a model State Cancer Remedy Act designed to control the promotion and sale of unproven methods of cancer management. This has already inspired nine states to legislate against cancer quackery—with active support from the medical community. Copies of the model act, as well as copies of the laws in effect, are available in our National and Division offices.

In these actions against cancer quackery, as in all our efforts against cancer, ours is a lifesaving partnership.

American Cancer Society

THIS SPACE CONTRIBUTED BY THE PUBLISHER

Ohio State Medical Association

BUDGET FOR 1975

The Ohio State Medical Journal	\$ 47,250.00
Executive Salaries	220,600.00
Staff Expense	35,000.00
Staff Associate, Secretarial and Clerical Salaries	125,064.00
President: 1974-75 Expense \$3500.00 Honorarium \$5000.00	,
1975-76 Expense \$3500.00	12,000.00
President-Elect: 1974-75 Expense \$2500.00 Honorarium \$2000.00	14,000,00
1975-76 Expense \$2500.00	7,000.00
Past President: 1974-75	2,000.00
Secy-Treasurer: Honorarium \$2000.00	2,000.00
Council Expense	25,000.00
A	30,000.00
AMA Delegate-Alternate Expense	30,000.00
COMMITTEES:	
Auditing and Appropriations	5,000.00
Cancer	400.00
Emergency and Disaster Medical Care	500.00
Education	7,500.00
Environmental and Public Health	500.00
Eye Care	400.00
Government Medical Care Programs	2,000.00
Health Care of the Poor	400.00
Health Manpower	1,500.00
Insurance	1,200.00
Jails and Prisons	600.00
Judicial and Professional Relations	200.00
Laboratory Medicine	600.00
Hospital Relations	200.00
Liaison Committee to Nationwide Insurance	100.00
Maternal Health	2,500.00
Medicine and Religion	200.00
Membership and Planning	500.00
Mental Health	2,000.00
Nursing	150.00
	950.00
OSMA-OSBA Liaison	400.00
Organ Transplant	
Placement Service	950.00
Podiatry Relations	100.00
Private Practice	200.00
Public Relations	600.00
Rehabilitation	100.00
Rural Health	1,000.00
School Health	5,000.00
Scientific Work	650.00
Workmen's Compensation	250.00

(Continued)

Annual Meeting	75,000.00
Building Expense	44,000.00
Car Lease Expense	9,600.00
Councilor District Conferences	3,000.00
Data Processing	25,000.00
Emergency Fund	12,000.00
Equipment Rental	20,000.00
Family Practice Scholarships	4,000.00
Field Service	6,300.00
Insurance and Bonding	25,000.00
Legal Expense	35,000.00
Library	1,250.00
OSMÁgram	10,000.00
Postage	20,000.00
Professional Relations Activities	8,500.00
Public Relations Department	45,224.00
Stationery, Printing and Supplies	17,500.00
Taxes: Payroll	22,000.00
Telephone and Telegraph	25,000.00
Depreciation	30,000.00
Furniture and Equipment	27,000.00
Contingency Reserve	100,000.00
~ ·	\$1,107,938.00
TOTAL BUDGET FOR 1975	\$1,107,330.00



The Professional Liability Crisis

What is the Ohio State Medical Association doing for you?

The Secretary of the Department of Health, Education and Welfare, Caspar W. Weinberger, said last month that professional liability is "a major crisis problem" facing our nation today.

At its 1974 Clinical Convention in Portland, the American Medical Association stated that professional liability took the highest priority in all matters facing the AMA this year.

On January 13, the outgoing Ohio Insurance Director Kenneth E. DeShetler called the "deteriorating market for medical malpractice insurance (in Ohio) a potential threat to the continued availability of health care services (in our state.)" He further stated that "the situation is likely to get worse until doctors, lawyers, insurance carriers, and public officials come up with a better way of preventing injuries and settling claims."

Your OSMA Headquarters has an effective clearinghouse in operation for you and your fellow members. Simply call (614) 228-6971. Your headquarters staff on a day-to-day basis has been able to place Ohio physicians in contact with insurance carriers willing to write acceptable programs.

Your officers and headquarters staff maintain ongoing discussions with the Ohio Supreme Court and the Ohio Bar Association. These discussions are aimed toward the goal of placing in effect appropriate sliding contingency fees. Additional conferences with the new Ohio Insurance Director, Harry V. Jump, and other state officials were begun last month and will be continued by your officers and headquarters staff.

Your OSMA officers and staff have a continuing relationship with the members of the Ohio General Assembly in order to help introduce appropriate legislation. Such legislation would establish:

- A Professional Liability Commission
- Standardized "informed consent" forms, which have been opposed by plaintiffs' attorneys
- A revision of the "Statute of Frauds" to limit physician liability for alleged verbal medical prognosis.

Your Ohio State Medical Association is working constantly to alleviate the professional liability crisis. In turn, YOU must coordinate your individual and group (surgeons, family practitioners, internists, anesthesiologists, OB-GYN, etc.) actions with OSMA. Only by coordinating all of their actions can physicians present a united program to solve today's crisis.

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50 North Third Street (OSMA Headquarters)

Singles	.\$23.00-\$26.00-\$29.00
Doubles	\$29.00-\$32.00-\$35.00
Studio	\$29.00-\$35.00
Suites	\$65.00

NEIL HOUSE MOTOR HOTEL

41 South High Street (OSMA Overflow Hotel)

Singles	\$18.00-\$20.00-\$22.00
Doubles	\$24.00-\$26.00-\$28.00
Twins	\$26.00-\$28.00-\$30.00-\$32.00
Parlor and 1 Bedroom	\$50.00-\$55.00-\$60.00
Parlor and 2 Bedrooms .	\$70.00-\$75.00-\$140.00

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Twins													.\$19.00-\$24.00

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300 East Broad Street (Woman's Auxiliary Headquarters)

Singles\$18.00-\$25.00
Doubles
Studio Twin\$26.00
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HOLIDAY INN — DOWNTOWN

175 East Town Street

Singles		17.50
Doubles	·	23.50

PICK-FORT HAYES HOTEL 31 West Spring Street

Singles	 								 \$18.00-\$22.00
Doubles	 ٠.								 \$24.00-\$28.00
Twins .	 								 \$24.00-\$28.00

All rates subject to change. If you plan to share a room, please indicate name of roommate.



HOTEL RESERVATION BLANK

(Mail to Hotel of Choice)

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	(Address)			
Please reserve the fol Meeting, May 11-14, 1 by April 19, 1975.	lowing accommodations during t 975 (or for period indicated). Not	he period of e: In order to	the Ohio State Med accommodate you, p	lical Association Ann please make reservation
	Single Room			Twin Room
	Double Room	Other	Accommodations	
Price Range		Guara	nteed	
Arrival: May		ıt	A.M	P
Departure: May		nt	A.M	P
	PLEASE VERIFY	MY RESERVA	TION	
Name				

1975 OSMA ANNUAL MEETING

PLANS ARE UNDERWAY

OUR MEDICINE IS GOOD: LET'S MAKE IT BETTER has been chosen as the 1975 Ohio State Medical Association Annual Meeting theme. Practically all OSMA Scientific Sections as well as many of the Specialty Groups will participate by sponsoring a scientific program in connection with the Annual Meeting. Dates are Sunday, May 11 through Wednesday, May 14 at the Sheraton-Columbus Hotel and the Veterans Memorial Building.

The first business session of the House of Delegates will be held on Sunday.

Monday's activities will start with Reference Committee Hearings at the Sheraton Columbus Hotel. Exhibits will open at noon and remain open until 4:00 p.m. The afternoon will be highlighted with a General Session type program as well as several specialty society meetings. A special "Open House" for all members will be held at the new home of Ohio State Medical Association, 600 South High Street, from 4:00-8:00 p.m.

Tuesday, May 13 will be a busy day with many of the scientific sections staging programs of particular interest to their specialty groups. Among programs of special interest will be those on Ohio Committee on Trauma, A.C.S., Rheumatology, Occupational Medicine, Chest Physicians, Ear, Nose and Throat, Internal Medicine, Neurosurgery, Ophthalmology and Pathology.

Wednesday, May 14 will be the last day of the meeting and will be filled with many educational activities. Programs which have been reported for Wednesday prior press time are sponsored by the Section on Allergy and the Ohio Society of Allergy and Immunology, Section on Plastic Surgery, Section on Dermatology and the Section on Sports Medicine. Thirteen Postgraduate Courses are offered on Tuesday and Wednesday. There is a \$15.00 registration fee for each course. They are as follows: Acid Base Disturbances and Blood Gases; Principles of E.K.G.; Chemotherapy of Infections — Bacterial, Viral, Fungus; Vascular Diseases — Venous and Arterial; Ischemic Heart Disease; Immunology Principles; Cancer: Treatment & Diagnosis; Emergency Room Medicine; Sexual Counseling; Chronic Lung Disease; Radioactive Isotopes: Advances in Diagnosis using radiology; ultrasound, isotopes; Cardiopulmonary Resuscitation; and Low Back Pain. More information on these courses will appear in the March issue in addition to a special mailing to all members.

Social Function: Remember the OSMA Social function will be held at the Country Dinner Playhouse at Reynoldsburg. OSMA will have the entire facility, including open bar, buffet dinner and a comedy show starring VAN JOHNSON. Buses will take our guests from the hotel to the playhouse and return them following the show.

Exhibits: Ohio has built a reputation for its outstanding Annual Meeting exhibits. Features will be Scientific, Health Education and Technical Exhibits. The technical exhibits are sponsored by many pharmaceutical manufacturers and other suppliers of physicians' needs.

Exhibits will be open on Monday, May 12 at 12:00 noon-4:00 p.m.; Tuesday, May 13, 9:00-4:00 p.m. and Wednesday, May 14, 9:00-3:00 p.m.

OMPAC Luncheon: Tuesday, May 13 the zany and glib MARK RUSSELL will provide entertainment at the luncheon.

House of Delegates: The meeting will start with the first session of the House of Delegates on Sunday, May 11. The final session will be held on Wednesday afternoon.

Registration for those attending the House of Delegates will open at 3:00 p.m. in the Sheraton-Columbus Hotel. Councilor District Caucus meetings will be held in hotel suites assigned to Councilors.

A buffet dinner for those attending the House of Delegates in an official capacity will be served at 5:30 p.m. in the Hotel. The business session will get underway at 7:00 p.m.

Reference Committee hearings will start at 8:30 a.m. on Monday, May 12 in rooms designated in the program. Hearings will continue on Monday afternoon.



Following are names of new members of the Ohio State Medical Association certified to the headquarters office during December. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

CUYAHOGA (Cleveland) Lon W. Castle Edward S. Sadar

FRANKLIN (Columbus) Joseph Henry Banks James Douglas Pritchard

HAMILTON (Cincinnati) Victor Yambing Cabanas Jerry Alan Goodman Ronald Kent Irvin James Anthony Mosso Suhail H. Naseri, Felicitas Alviar Perez Richard John Watson

LORAIN Teresita Del Ca Cruz Lorain Shabbir Ahmad Naeem Elyria

MONTGOMERY

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SCIOTO George F. White Portsmouth

Student American Medical Assn. Names New Executive Director

The Student American Medical Association has appointed a new executive director, Louis R. Giancola, who says that the organization "has a tremendous opportunity to provide non-self-interested leadership in shaping the future of health care in the U.S."

Giancola, 29, previously worked for the U.S. Public Health Service where he was involved in developing and administering health service delivery programs for underserved areas. His background includes a M.P.H. in medical care administration from the University of Michigan and a B.S. in industrial and labor relations from Cornell University.

According to The New Physician, Giancola hopes to be able to make necessary changes in the medical care system by working with medical students. "I believe that SAMA is in a unique position to improve the delivery of health services by providing direction for the future of medical education, influencing health legislation, and providing medical students with information on health issues," he said.

His first priority, according to Giancola, will be to "broaden the organization's membership base by working with local chapters and to define pertinent issues and strategies for necessary action." He is convinced that SAMA's national activities must be grounded in strong local chapters.

More than a million dollar gain in revenue has been recorded for the third consecutive year by the Leukemia Society of America, Inc. in its annual report for 1974. The report, covering the fiscal period which ended in June, shows a total income of \$7,531,375 compared with \$6,427,073 for the same time span in 1973. The Society has funnelled \$1,564,269 into current research to support 106 medical scientists working at 58 institutions in 20 states and six foreign countries.

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The State Medical Board elected new officers on January 8, 1975. Seated left to right are: Sanford Press, M.D., Steubenville, newly-elected secretary; Anthony Ruppersberg, Jr., M.D., Columbus, president; and William J. Timmins, Jr., D.O., Warren, vice president. Standing left to right are: Henry A. Crawford, M.D., Cleveland; John D. Brumbaugh, M.D., Akron; Henry G. Cramblett, M.D., Columbus, immediate past president; Peter Lancione, M.D., Bellaire; and Roland A. Gandy, Jr., M.D., Toledo.

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1975 Annual Meeting, Ohio State Medical Association

DO YOU HAVE AN EXHIBIT or know of an exhibit which is of scientific interest? If you do, the Ohio State Medical Association Annual Meeting is just the place to display it. We are now accepting applications for the 1975 OSMA Annual Meeting. Those eligible to apply are as follows: (1) Exhibits by Ohio physicians, Ohio medical schools, hospitals or similar organizations; (2) Out-of-state physicians or out-of-state agencies on invitation; (3) Voluntary health organizations.

Exhibits will be set up and viewed at the Veterans Memorial Building, 300 West Broad Street, Columbus, Ohio. Exhibit Days and Times will be as follows: Monday, May 12 — 12:00 Noon - 4:00 P.M.; Tuesday, May 13 — 9:00 A.M. - 4:00 P.M.; and

Wednesday, May 14 — 9:00 A.M. - 3:00 P.M.

Mail applications to the attention of J. E. Tetirick, M.D., Chairman, Committee on Scientific Work, Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215.

APPLICATION FOR SPACE SCIENTIFIC EXHIBITS

1975 Annual Meeting, Ohio State Medical Association

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An exhibit presented by two Ohio physicians was named "the outstanding exhibit, especially for educational matters" at the 1974 AMA Clinical Convention in Portland. Drs. John M. Tew, Jr. and Frank H. Mayfield, both of Cincinnati, received the Hull Award for their exhibit "Trigeminal Neuralgia: A New Surgical Approach." In this photograph, Dr. Tew (right) discusses his exhibit with an Illinois physician, Dr. Frank Sutkus.

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ARNOLD H. KAMBLY, M.D. Psychiatrist-Director

The drug industry in the United States spent more that \$800 million this year on research and development of products. The research capability of the U.S. pharmaceutical industry is responsible for 92 percent of the medicines developed in this country. The remainder has originated in university or government laboratories. Through the pharmaceutical industry's research and development activities:

- U.S. drug firms have discovered and introduced into U.S. medical practice about 520 new drugs (single-chemical entities) in the last 30 years. The next most productive nation is Switzerland, with 60 drug discoveries.
- U.S. pharmaceutical industry scientists evaluate 8,000 chemical compounds for each new medicine a doctor prescribes. The discovery and development of a new medicine may have cost as much as \$15 million and may have required 8 to 10 years of clinical trials and testing.
- U.S. pharmaceutical companies form the most research-intensive industry in the nation, investing 5 times as much of its sales income on research as does American industry overall. The drug industry pays for 99 percent of its research, while the government supports the remaining 1 percent. Government funds pay for an average 44 percent of the research conducted by all other American industries.

Stark County Elects Officers

Dr. Henry H. Clapper, Canton, was installed as President of the Stark County Medical Society at its 71st Annual Meeting. Selected as President-Elect for 1976 was Dr. J. P. Yut.

Dr. W. J. Howland was elected to the position of Secretary-Treasurer. Dr. A. J. Demis was named to the Board of Censors, joining holdover members Dr. Jerry Rothenberg, Alliance; Dr. William Martin, Massillon; and Drs. James King, William A. Simmons and R. L. Watterson, Jr., all of Canton.

Re-elected as Delegate to The Ohio State Medical Association was Dr. E. E. Grable, Canton. Other delegates are Dr. Frank O. Goodnough, Massillon; Dr. E. J. Davis, East Canton; and Dr. William A. White, Canton. Alternate Delegates are Dr. J. D. Botti and Dr. J. P. Yut, Canton; Dr. Daniel A. Kibler, Alliance; and Dr. Bryan Harrold, Massillon.

Dr. Clapper received his BA and MD degrees from Ohio State University and is a graduate of the Graduate School of Surgery, University of Pennsylvania. Following a three year surgical residency at Mercy Hospital, Canton, he served as Chief Surgical Resident at Highland Hospital, Rochester, New York. Dr. Clapper is a past chair-

man of the Department of Surgery of Timken Mercy Hospital, a diplomate of the American Board of Surgery, Fellow of the American College of Surgeons, and a member of the American Proctological Society, American Burn Society, and American Medical Association. He is on the active staff of Timken Mercy Hospital and the courtesy staff of Aultman Hospital.

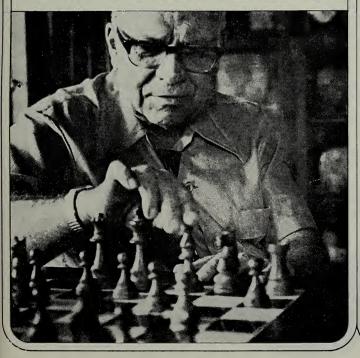
President-Elect Dr. J. P. Yut is a graduate of The University of Pittsburgh, and The George Washington University School of Medicine. He completed his special training at The Jefferson Medical College Hospital, in Philadelphia, Pennsylvania. Dr. Yut is a Diplomate of The American Board of Otolaryngology, a Fellow in The American Academy of Ophthalmology and Otolaryngology, and a Fellow in The American College of Surgeons. He is a member of the Medical Staff at Aultman Hospital.

Dr. Charles E. Holzer, Jr., Chief of Staff at the Holzer Medical Center, has been honored as an outstanding alumnus of Haverford College.

Holzer, of 525 First Ave., Gallipolis, was named one of four recipients of the 1974 Haverford Award, presented annually to graduates who best reflect the college's stated concern that knowledge be applied to socially useful ends.

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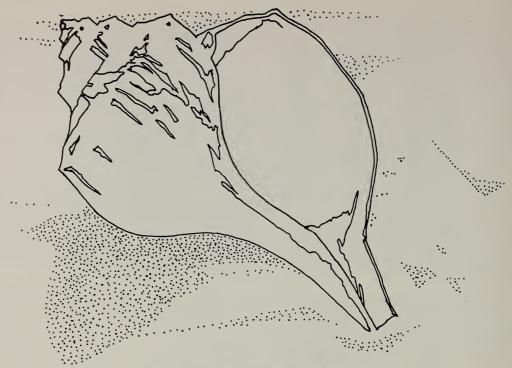
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For more information, write: Dept. of Circulation & Records, AMA 535 N. Dearborn St., Chicago, IL 60610



Ohio Libraries Offer Special Services For The Handicapped

Ohioans with handicaps face special problems in using public libraries. A new directory, *Libraries for People with Handicaps*, lists special services and materials available to them in 238 of Ohio's 250 public libraries.

The 47-page booklet, published by The State Library of Ohio, shows that a variety of services are available to meet many different needs. Libraries deliver materials to people who cannot go to the library, place collections of books in nursing homes, residential centers and other areas where people with handicaps congregate, and present programs to special groups within or outside the library.

The directory also lists the materials and equipment libraries provide for people who cannot use ordinary print. These include music and spoken word records and cassettes, large print books, magnifiers, page turners, films, slides, framed pictures, and prism glasses for the bedfast person.

Ohio libraries are increasing the accessibility of their buildings to people with handicaps. The directory indentifies libraries which have made provisions for the person who is unsteady or in a wheelchair.

Copies of Libraries for People with Handicaps are available in public libraries throughout Ohio. Single copies are also available without charge from The State Library of Ohio, 65 South Front St., Columbus 43215.

Deadline for Submission of Resolutions to OSMA Office is March 12

Delegates to the Ohio State Medical Association and County Medical Societies planning to have resolutions submitted for consideration by the House of Delegates at the 1975 Annual Meeting should be guided by Chapter 4, Section 8 of the OSMA Bylaws entitled "Resolutions."

"Every resolution to be presented to the House of Delegates for action shall be filed with the Executive Director of the Association at least (60) days prior to the first day of the meeting at which action on such resolution is proposed to be taken; and promptly upon the filing of any such resolution the Executive Director shall prepare and transmit a copy thereof to each member of the House of Delegates. No resolution may be presented or introduced at any meeting of the House of Delegates unless the foregoing requirements for filing and transmittal shall have been complied with or unless such compliance shall have been waived by a Special Committee on Emergency Resolutions named to decide whether late submission was justified. This special committee shall consist of the chairmen of the several resolution committees. If a majority of the members of the Special Committee on Emergency Resolutions vote favorably for waiving the filing and transmittal requirement, then such resolution shall be presented to the House of Delegates at its opening session. All resolutions presented subsequent to the 60-day filing date prior to the opening session of the House of Delegates shall be submitted by their sponsors to the committee no less than 12 hours prior to the opening session of the House of Delegates."



Lipid Research Renewed At U. of Cinn. Medical Center

The Lipid Research Clinic at the University of Cincinnati Medical Center has been awarded a two-year renewal contract worth \$1,785,700.00 by the U.S. National Heart and Lung Institute. The Lipid Research Clinic offers a free cholesterol measurement program for men 35 to 59 years of age.

The University of Cincinnati's contract was one of 14 awarded by the National Heart and Lung Institute to universities participating in its Lipid Research Clinics Program. Announcement of the contracts was made in Washington by Casper W. Weinberger, Secretary of the U.S. Department of Health, Education and Welfare. The National Heart and Lung Institute is a Bureau of the National Institutes of Health, one of six agencies comprising HEW's Public Health Service.

The seven-year national study began in 1973. It is designed to assess the effectiveness of measurements for reducing elevated blood cholesterol levels in preventing or slowing down the development of premature atherosclerosis, coronary heart disease, and such consequences as angina pectoris, acute heart attacks, and sudden cardiac death.

The University of Cincinnati clinic has recently extended the cholesterol testing opportunities to Greater Cincinnati industries and companies, as well as to individuals. The men already enrolled in the trial have not developed overt signs or symptoms of coronary heart disease, but their risk of doing so is increased by a blood-lipid disorder called hypercholesterolemia.

When this disorder is diagnosed, the Lipid Research Clinic provides free courses of evaluation and treatment, chiefly dietary advice and medication. All medical and dietary treatment programs are carried out in conjunction with, and with the approval of, the individual's family physician or, in the case of business or industrial groups, the company physician or individual's physician.

The University of Cincinnati Medical Center and Brown County General Hospital in Georgetown, have signed an affiliation agreement for students and faculty members to participate in education and service elements of Brown County General Hospital. The agreement will enable medical, nursing, and pharmacy students to participate in primary care delivery in a rural setting.

Brown County General Hospital is a 140-bed, fully accredited hospital which serves a population of 40,000 in the surrounding rural area. Through an Appalachian Regional Commission grant, an ambulatory patient care unit will soon be opened at Brown County General Hospital which will be used as an educational as well as a service facility.

The agreement initiates a program designed to alleviate problems of health manpower shortages and maldistribution.

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Woman's Auxiliary Highlights

Mrs. S. L. Meltzer, Communications Chairman 2442 Dorman Drive, Portsmouth 45662

International Health Activities

In the Words of a charming and gifted doctor's wife in Scioto County who, most fittingly, is the state auxiliary's International Health chairman: "Through instant communication and jet travel, we rapidly have become a world community — interdependent and interwoven in many phases of our existence our International Health Activities are directed toward worldwide health concerns. . . ."

The speaker is Mrs. Armin Melior and she is a native of Germany. I used the words "most fittingly" in describing her chairmanship because if anyone has the "feel" of what International Health is and should be, it is she with her warmth of understanding and keen awareness of what is going on all over the world health-wise. She and Dr. Melior have travelled extensively. She has lived virtually two different lives, her "before" in Germany, her "after" (25 years) in America. She has her finger on the pulse of health all over the world. In this month of February, usually so cold and bleak, we can look to our International Health activities to radiate some warmth and sunshine.

Following the National Auxiliary's program of IHA, Mrs. Melior has set up four interest areas:

- 1) Think International. Educate our own members, friends and community in a greater basic understanding of foreign people and of world events using such avenues as: Speakers who helped with missionary medicine or with the Peace Corps or our own members who have traveled; Book Reviews about foreign medicine; Films such as that on "Project Hope" available from Sterling Movies, 200 S. Michigan Avenue, Chicago 60604, (no charge); and finally News Items collected by members that touch on health work around the world.
- 2) Agency Assistance. Thousands of tons of supplies go each year from doctors' wives to the collection agencies. Here is where the size of the auxiliary does not matter any group, any size, can participate. The most widely used agency for Ohio is the World Medical Relief, Inc., 11745-125th Street, Detroit, Michigan, 48206. Mrs. Melior suggests that it is a good idea to contact the agency before starting to collect things to determine the needs and to receive mailing instructions. The items for which there has been the greatest demand include medical, surgical, dental, orthopedic, optical, X-ray and laboratory supplies as well as sample pharmaceuticals which must be within expiration date and unopened and of



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course there must be no narcotics. Auxiliaries may involve WA-SAMA, scouts, church and other community groups and people in institutions (occupational therapy) to make such things as sleeping mats, quilts, toys and layettes. IHA has a really meaningful slogan: "Don't throw it away; recycle it for IHA"! Along with the vital material things, there is the vital human angle — trained people (physicians, paramedical personnel) are badly needed. Ille Melior has a list of such possibilities.

3) Hospitality Here. That means making friends for our country, our county and medicine. And here is how many of our auxiliaries do it: assist foreign families with a welcome kit, translating, shopping and tutoring; act as a host family in sharing holidays and hobbies; plan international programs with a speaker, movies or other activities; arrange picnics for the wives and children of the foreign doctors; "adopt" a foreign student to share family events; make a special effort of welcome to medical personnel living in your area; invite foreign doctors' wives to auxiliary meetings. In other words, remember that "the only way to have friends is to be one."

4) Friendship Over There. That, of course, has to do with extending goodwill across the seas with such programs as: the services of doctors and medical personnel in deprived areas overseas. Many agencies are eager to arrange either short or long term service in a foreign land. Then there is the "Pen Pals" project — the "matching up" of one doctor's family with another by way of happy correspondence, one "pen pal" to another — the comparing of different life styles, the offering of warm friendship. Still another possibility is Scholarships for Children of International Physicians. This project began in India. Indian doctors were willing to practice in rural areas if their children could be sent away to school. For thirty dollars a month, an auxiliary or an individual can "adopt" such a child. The International Book

Project is another outstanding activity: this agency is run by a doctor's wife in Lexington, Kentucky and sends donated books and journals overseas and "matches" people in the person-to-person aspect. Project Hope (Health Opportunities for People Everywhere) continues to hold a most important place in the International Health program. Auxiliaries are urged to take a Hope Membership (anywhere from ten dollars up). The money may be sent directly to: Project Hope, Dept. A, Washington, D.C., 20007. Incidentally, a favorite county auxiliary project these days is the making of "johnny coats" out of donated white or pastel men's shirts.

In giving this rundown on the Auxiliary's International Health project, I have barely skimmed the surface. Ille Melior has ever so much more detailed and interesting information and she'd be delighted to hear from you. . . and you. . . and you. Write to her at Cook Road, Route 1, Lucasville, Ohio, 45638. St. Valentine's Day this month emphasizes thoughtfulness and love. So does our International Health program!

A minor planet has been named in honor of Edward A. Gall, M.D., a University of Cincinnati Medical Center pathologist. The planet, first sighted in 1916, was officially dubbed "Granule" to commemorate Dr. Gall's discovery of a specific granule in lymphocytes. This unusual distinction was announced when Dr. Gall retired as University Vice President and Director of the Medical Center last June.

A total of 53,597 medical students are enrolled in the nation's 114 medical schools this year, a 5 percent increase over the 50,716 reported in 1973-1974. Of the total 14,763 first-year students, 22 percent are women. There are 1,106 black firstyear students, an 8 percent increase over last year.



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IN MEMORIAM

EDWARD J. McCORMICK, M.D. 1891-1975 PHYSICIAN, SURGEON, SCHOLAR, STATESMAN, PATRIOT, CITIZEN AND GENTLEMAN



Past President of the American Medical Association 1953-54
Past President of the Ohio State Medical Association 1942
Past President of the Academy of Medicine of Toledo and
Lucas County 1926

Fellow of the American College of Surgeons

Diplomate of the American Board of Surgery

United States Army Medical Corps Reserve 1917-1919

British Expeditionary Force in Europe

United States Navy Medical Corps Reserve 1923-1929

United States Public Health Service Reserve 1943-1946

Dr. McCormick is survived by his widow, Mrs. Josephine McCormick of 4350 Northmoor Road, Toledo; and five children: Rev. Richard McCormick, Edward J. McCormick, Jr., Mrs. Carol Sala, Mrs. Kathleen Brooks, and Mrs. Mary Jo Anderson.

Obituaries

Karl Herman Barth, M.D., New Washington; Ohio State University College of Medicine, 1917; age 83; died December 8; member of OSMA and AMA.

Don Franklin Cameron, Sr., M.D., St. Petersburg, Florida; Johns Hopkins University School of Medicine, 1913; age 85; died December 18; member of AMA.

William Howard Carter, M.D., Columbus; Ohio State University College of Medicine, 1949; age 63; died November 29; member of OSMA and AMA.

Kenneth W. Clement, M.D., Cleveland; Howard University College of Medicine, 1945; age 54; died November 29; member of OSMA and AMA.

Arthur E. Coyne, M.D., Newark; Loma Linda University School of Medicine, 1918; age 81; died November 17; member of OSMA and AMA.

Gerald Patrick Davey, M.D., Cuyahoga Falls; Georgetown University School of Medicine, 1943; age 58; died December 25; member of OSMA and AMA.

Homer George Deerhake, M.D., Lima; Ohio State University College of Medicine, 1929; age 70; died November 23; member of OSMA and AMA.

Eugene Miles Fusco, M.D., Columbus; Ohio State University College of Medicine, 1935; age 63; died December 15; member of OSMA and AMA.

Clarence T. Hemmings, M.D., Erie, Pa.; Western Reserve University School of Medicine, 1912; age 86; died December 29; member of OSMA and AMA.

Ross A. Hill, M.D., Middletown; Hahnemann Medical College of Philadelphia, 1927; age 80; died December 24; member of OSMA and AMA.

Hobart Hoeger, M.D., Marlin, Texas, Eclectic Medical College, Cincinnati, 1928; age 72; died November 30.

John Crawford LaVoo, M.D., Warren; University of Cincinnati College of Medicine, 1940; age 62; died December 6; member of OSMA and AMA.

Richard Lee Morgan, M.D., Marion; Ohio State University College of Medicine, 1940; age 60; died December 7; member of OSMA and AMA.

William Dewey Patton, Jr., M.D., Middletown; Meharry Medical College School of Medicine, 1944; age 57; died December 13; member of OSMA and AMA.

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Daniels-Head & Associates, Inc105
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Pharmaceutical Manufacturers Association
Roche Laboratories, Div. of Hoffman- LaRoche, Inc Inside Front Cover, 65, 90, 91, 96, 97, Inside Back Cover, Back Cover
Roerig & Co., Div., Pfizer72
G 1 111 G 77
Schmidt's Sausage Haus122
Schmidt's Sausage Haus
Searle Laboratories, Division of
Searle Laboratories, Division of G. D. Searle & Co
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respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

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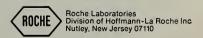
surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies.

Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle

spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.





VOL. 71

MARCH, 1975

NO. 3

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A. H. Robins Refunds Physicians' Unused Stock of Dalkon Shields

A. H. Robins Company, the Richmond, Va. based pharmaceutical manufacturer, issued the following statement on January 20 in response to questions concerning the disposition of unused stocks of its Dalkon Shield® intrauterine contraceptive device (IUD).

Since last June, when it voluntarily suspended distribution and sales pending a Food and Drug Administration study, A. H. Robins has been accepting the return of unused stocks of its Dalkon Shield intrauterine contraceptive device. At the time of the FDA's report on the study last December, the company anticipated exchanging newlypackaged devices for any remaining unused Dalkon Shields, consistent with its intention that all future sales and insertions of Dalkon Shields in the United States be with devices supplied with new monofilament strings, new labeling, new physician and patient brochures, and patient registry material. Since it is apparent that the latter items, now being developed in concert with the FDA, will not be available for several months, the company has taken the additional step of directing its sales representatives to visit wholesalers, physicians, hospitals, birth control organizations, and other users of IUDs to pick up and give refunds for any remaining unused Dalkon Shields. In so doing, the company emphasizes that the Food and Drug Administration has stated that women presently using the Dalkon Shield without problems are advised to continue under the normal supervision of their physicians.

Health Care Spending in '74

The Office of Research and Statistics (HEW) recently released detailed data and analysis of fiscal year 1974 health spending. Some interesting facts contained in this information are:

—U.S. health spending reached \$104.2 billion

and amounted to \$485 per capita.

—The increase in spending was 10.6%, a slightly higher rise than that registered in fiscal year 1973 when mandatory economic controls were fully in effect for the health industry.

—Despite this slight acceleration in 1974, health expenditures remained at the 1973 proportion

of GNP—7.7%.

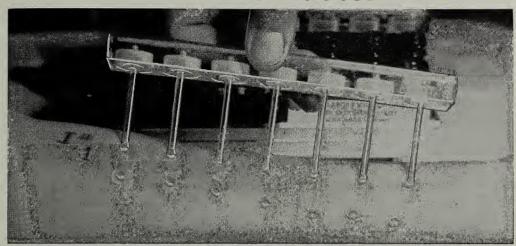
-Public spending increased twice as fast as private due mainly to substantial increases in expenditures under the Medicare and Medicaid programs.

-Hospital care continued to be the largest expenditure category accounting for 39% of total

-Expenditures for hospital care totaled \$40.9 billion while physicians' services accounted for \$19 billion.

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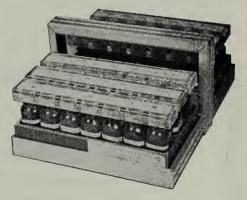
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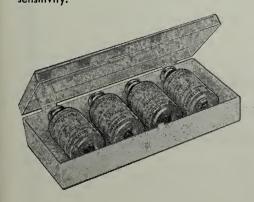
This easy three-step allergy test kit contains 42 Allergens, clinically selected. The new testing technique allows you or your nurse to apply 7 different drops of potent allergens to the skin at one time. It's economical, fast . . . allowing you to manage allergy diagnosis with minimum time and cost.

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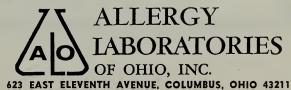
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Federal Regulations Concerning Sterilization Procedures

TO: Physicians, Hospitals and Clinics

FROM: Denver L. White, Director

Ohio Department of Public Welfare

Specific regulations were recently issued by the Department of Health, Education and Welfare relative to sterilization procedures and the Medicaid Program. They are as follows:

- Payments for sterilizations of individuals under the age of 21 or of individuals legally incapable of consenting to such a procedure (such as the mentally ill or mentally retarded) are prohibited under the Medicaid Program.
- Sterilization procedures will be reimbursed for those individuals 21 years of age or over if the following requirements are met.
 - a) The sterilization must be the result of a voluntary request for such services by the recipient legally capable of consenting to such a procedure.
 - b) Informed consent must be obtained from the recipient by means of a completed consent to sterilization form, DPW 3198, a copy of which is attached.
 - c) The recipient must be advised at the outset and prior to giving his or her informed consent to the procedure, that no program or project benefits, to which he might otherwise be entitled, may be withdrawn or withheld by reason of his or her decision to be sterilized.
 - d) The recipient's "auditor-witness" must be present for the oral presentation of the recipient's rights and options.
 - e) The sterilization procedure must not be performed earlier than 72 hours following the giving of informed consent.

Effective February 7, 1975,, all invoices for sterilization procedures must be accompanied by the completed consent of sterilization form. All invoices not accompanied by this form will be returned to the provider.

Due to the unavailability of printed forms at this time, physicians, clinics, and hospitals are requested to Xerox copies of the sample copy of the form attached to this letter. Three copies of the consent form are to be prepared—original for billing, first copy for your files and second copy for the patient. We deeply regret having to request this additional burden, but we are unable to get printed copies of this form until March 17, 1975.

Printed copies of the consent to sterilization form (DPW 3198, see opposite page) can be obtained after March 17. 1975 from the following address:

Ohio Department of Public Welfare Division of General Support Services Bureau of Supportive Services 227 North Front Street Columbus, Ohio 43215



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Original — Forward to O.D.P.W. with Billing Invoice

(Physician to check appropriate procedure)

2nd Copy — Provider Copy 3rd Copy — Recipient Copy

OHIO DEPARTMENT OF PUBLIC WELFARE CONSENT TO STERILIZATION

This consent form is for the use of recipients who are at least twenty-one (21) years of age. Under current Federal regulations, Medicaid funds cannot be used to pay for sterilization procedures performed on recipients who are under the age of twenty-one (21).

NOTICE

YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWING OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS.

Sterilization is defined as any procedure by which one is made incapable of having children, such as salpingectomy, hysterectomy, vasectomy, etc. It should be recognized that any surgical procedure carries with it a certain element of risk; however, few side effects are experienced nowadays when sterilization is performed. Men are usually able to return to work the day following their minor surgery. Some sterilization procedures for women involve entering the abdomen; therefore, the risks involved are similar to those following any abdominal surgery (for example, post-operative bleeding at the surgery site could occur). Any unusual occurrences following your sterilization, such as sudden bleeding, should be reported to your physician immediately.

Although the effects of certain of these procedures can sometimes be reversed, sterilization must always be considered as an irreversible procedure.

Choice of a sterilization procedure is normally made following an examination by your physician and discussed with him to select the method most suitable for you. Alternative methods of family planning, which will allow you to have children if discontinued, such as intrauterine devices, diaphragms, oral contraceptives, condoms, etc., should be discussed at this time and prior to the signing of this consent form.

The risk of failure must also be recognized, although the percentage of pregnancies subsequent to sterilization is extremely small.

The major benefit of sterilization, of course, is that it not only removes the fear of unwanted pregnancies, but also eliminates the necessity for alternative methods of family planning. It is very reliable, effective and convenient.

The following sterilization procedure will be performed no earlier than 72 hours following the signing of this consent form:

Ligation and excision of porti Fallopian Tubes	ion of	Н	ysterectomy
Laparoscopic sterilization by s or electrocoagulation of tub		V	asectomy
Sterilization by hemoclips		o	ther (please specify)
I have read the above and have had t to my satisfaction. I hereby certify that mance of the designated sterilization p signing of this form, during which time	I am at least twenty-one (21) years of rocedure. The surgery will not be sche	age and give duled earlier t	my consent to the perfor-
Signature of Recipient	Recipient Number	surgery (or	f physician performing the appropriate person desig- e physician)
Signature of Spouse, If appropriate	Signature of Auditor-Witness (Designated by Recipient)		Date and Time

Ohio Department of Health

JOHN H. ACKERMAN, M.D., Director

Influenza in Ohio — February I, 1975

The Communicable Disease Division, Ohio Department of Health has maintained an intensive influenza surveillance program throughout the State since November 1, 1974. Weekly absenteeism in selected industrial plants and schools in Cincinnati, Columbus, Cleveland, Dayton, and Toledo has been monitored. Weekly emergency room visits in a large hospital in Columbus and a large hospital in Cleveland have also been surveyed. Attempts at viral isolation have been made by physicians in several areas of the State from patients with appropriate clinical syndromes.

Influenza A, antigenically similar to the A/Port Chalmers/1/73 virus, has been isolated from a number of areas of the United States. Morbidity, as measured by absenteeism, and mortality, based on pneumonia and influenza deaths, from influenza have been elevated since late December in many of these areas. The Southeast has been the most severely affected.

Influenza A was isolated in Ohio for the first time during this season, in January from patients in Cincinnati, Columbus and Cleveland. Several of the isolates are antigenically similar to the Port Chalmers virus. Through the month of January, absenteeism throughout Ohio has not been significantly elevated. Emergency room visits at the Cleveland hospital have remained unchanged, while an increase of 20% at the Columbus hospital was sustained for two weeks in January, and then returned to normal, Several isolated outbreaks of probable influenza in schools have been reported from various parts of the state. There have been no laboratory confirmed outbreaks of influenza at this time. Pneumonia and influenza deaths have been slightly above the epidemic threshold for the first three weeks of January in the East North Central portion of the United States, which includes Ohio.

Therefore as of this writing, influenza A virus has been documented in Ohio for three weeks. Mortality attributable to influenza has been elevated slightly, however, indices of morbidity have not been influenced.

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g and abdominal cramps. The reaction is usually transient. NDICATIONS: As a cerebral stimulant and vasodilator. ECOMMENDED GERIATIC OOSAGE: One capsule three times ally adjusted to the individual patient. cause muscle tremor and con-

vulsions.
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Severe Ankle Injuries While Wearing Elevated "Platform" Shoes

Ernesto Nieto, M.D. Stanley H. Nahigian, M.D.

Many minor ankle and foot injuries have occurred while wearing the fashionable elevated or "platform" shoes. These shoes may have soles elevated as much as 4 cm, heels 15 cm, and are worn by male and female alike. Physicians and patients should be made aware of the serious potential hazards while wearing these "platform" shoes.

IN THE FAST-CHANGING WORLD of fashion, women as well as men have worn a wide variety of shoes. During the past year, the stylish high, or "platform" shoes have proven to be hazardous, causing several types of injuries to the soft tissues and boney structures of the ankle and foot areas. These particular shoes are designed with a raised sole, ranging in height from 2 to 4 cm. The elevated heel measures up to 15 cm in height with a wide shape and is best described as "chunky."

All across the nation, physicians and emergency room personnel have treated and released

many patients with sprained ankles caused by wearing such shoes. These shoes also produce an unusual angle of elevation between the forefoot and the heel, resulting in a greater load on the metatarsal heads. This causes metatarsalgia, a common complaint of the wearer of the shoes, more frequently in the unexperienced wearer. No major ankle fractures have been reported previously.

In addition to many minor ankle and foot injuries, we have treated some particularly severe injuries to the foot and ankle that occurred while the patient was wearing "platform"-type shoes. We are reporting six such cases that support the potential hazards of these shoes.

The injuries have consisted of fractures to the ankle area, including four cases with displaced bimalleolar fractures, one case with a fracture of the lateral malleolus, and one case with a nondisplaced fracture of the calcaneous.

In this series, there were three male and three female patients. The youngest one was 26 years old and the oldest was 46 years of age.

All the cases with bimalleolar fractures were treated surgically and the other two cases with cast immobilization, as shown in the Table.

Case Reports

Case 1.—A 36-year-old white man was admitted on June 11, 1973, with a history of a fall while walking with his high shoes on a flat surface. The patient reported he "twisted" his ankle. The mechanism of injury in this case was an inversion motion with external rotation of the ankle. Roentgenograms (Fig. 1) showed a posterior dislocation of the right ankle with a displaced comminuted

Dr. Nieto, Cleveland, Orthopedic Resident, St. Luke's Hospital.

Dr. Nahigian, Cleveland, Staff Member, St. Luke's and St. Vincent Charity Hospitals; and Clinical Instructor, Case Western Reserve University School of Medicine.

Reprint requests to 3461 Warrensville Center Road, Shaker Heights, Ohio 44122 (Dr. Nahigian). Submitted April 17, 1974.

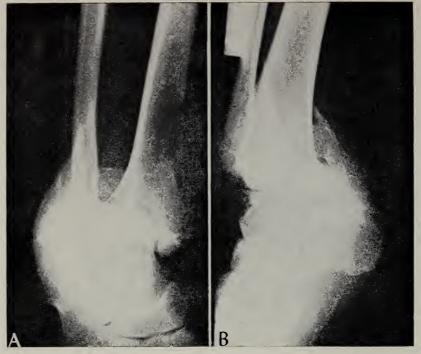


Fig. 1.—Case 1. AP (A) and lateral (B) roentgenograms showing posterior dislocation of right ankle with displaced comminuted fracture of lateral malleolus and avulsion fracture of medial malleolus.

fracture of the lateral malleolus, as well as a comminuted avulsion fracture of the medial malleolus. Reduction of the dislocation was done in the emergency room. An open reduction with circular wire fixation of the lateral malleolar fracture was performed the same day. The medial malleolus was too comminuted for internal fixation (Fig. 2). Below-knee cast immobilization was continued until August 15, 1973. The patient has returned to work.

Case 2.—A 26-year-old white woman was admitted

Case 2.—A 26-year-old white woman was admitted on August 22, 1973, with pain and deformity of the right ankle. The patient gave a history of falling and twisting her right ankle when her high shoe loosened while she was walking on the sidewalk, just prior to admission. X-ray films (Fig. 3) showed a displaced fracture of the posterior and lateral malleolus. The fracture line involved the weight-bearing surface of the tibia. The mechanism of

fracture in this case was that of an eversion-type of injury with external rotation of the foot in equinus.

On admission, a closed reduction was carried out. Postreduction roentgenograms showed some displacement of the fibular fragment. Therefore, on August 24, 1973, an open reduction was performed through a posterior lateral approach; the posterior malleolar fracture was fixed with two screws and the fibular fracture was reduced and fixed with two circumferential wires (Fig. 4). The patient was discharged on September 1, 1973 with a long-leg, nonweight-bearing cast, which was removed four weeks later. The patient has returned to work.

later. The patient has returned to work.

Case 3.—On November 3, 1973, this 32-year-old black man slipped going down the stairs and sustained a direct trauma to the sole of his right foot, as well as a "twisting" injury to his ankle, while wearing platform

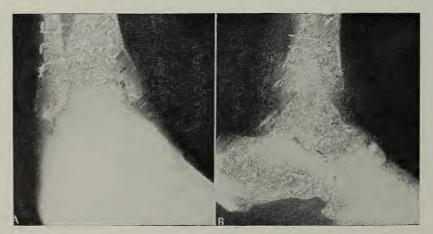


Fig. 2.—Case 1. Two-month postoperative AP (A) and lateral (B) roentgenograms after plaster cast was removed.



Fig. 3.—Case 2. Preoperative AP (left) and lateral (right) roentgenograms showing displaced fractures of lateral and posterior malleolus.

shoes. The patient complained of pain over the lateral malleolus, however, x-ray films (Fig. 5) revealed a non-displaced fracture of the calcaneous, with a normal Böhler's angle, and involvement of the subtalar joint. The patient was treated on an ambulatory basis with short-leg-cast immobilization and crutches. On January 28, 1974, the patient was seen without the cast, which he had removed. He has been lost to follow-up.

Discussion

It is not the purpose of this paper to classify or discuss the different types of ankle fractures and their treatment but, rather, report the etiology of the fractures in this short series. We have classified the fractures simply as malleolar or bimalleolar, displaced or nondisplaced. The treatment used followed the general principles of the treatment of ankle fractures, depending on the structures involved, the severity of the injury, and the grade of instability of the fracture. Closed and open modalities were used accordingly and means of internal fixation such as screws, wires, or nails, depending on the individual case and the personal judgment of the particular surgeon (See Table).

All the injuries in this series were due to the use of high or towering footwear. These so-called platform, clog, or clunkers are characterized by a high "chunky" heel which measures 7 to 15 cm in height.

In all the cases, the mechanism of the injury was reported as a twisting action of the ankle. This twisting action is the result of a loss of balance caused by the great distance, because of the high heel and sole, between the ground and the plantar surface of the foot. The resulting force is produced by either the inversion (Fig. 6) or eversion (Fig. 7)

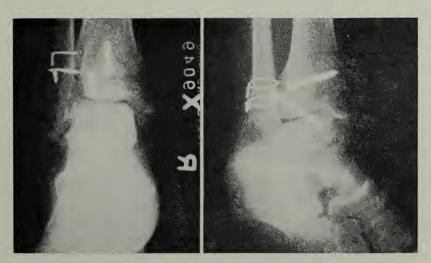


Fig. 4.—Case 2. Six-week postoperative AP (left) and lateral (right) roentgenograms showing fixation of posterior malleolus with screws and fibular fracture with circular wires.

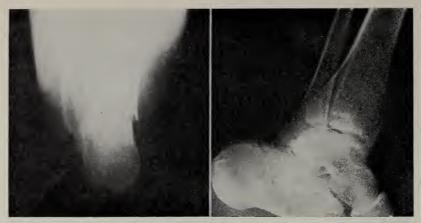


Fig. 5.—Case 3. AP (left) and lateral (right) roentgenograms showing nondisplaced fracture of right calcaneous. There is involvement of subtalar joint, but Böhler's angle is normal.

mechanism, the two lateral motions of the foot at the ankle joint. In other words, lateral rotation and eversion. However, these two actions can happen simultaneously. This has been the conclusion of Kleiger¹ after his research and extensive bibliographic review. He also concluded in his work that more than one force may cause a given ankle injury. Eversion and lateral rotation are a common combination—these two forces simultaneously or one after another in rapid sequence. A lateral rotation force applied to the ankle, by lateral rotation of the foot, tears the anteromedial capsule and

ligaments. The severity of the strain may cause a rupture of the deltoid ligament and the widening of the mortise resulting in displacement of the talus, which strikes over the fibular area producing a fracture.

The medial malleolar fracture, transversely or obliquely, would be the result of an eversion force, which pulls the medial malleolus laterally across its narrow base. With "platform" shoes, these actions seem to happen in a rather rapid sequence, depending on the rapidity of the accelerating force that breaks the equilibrium between the foot and the

Clinical Data for Cases of Injuries Sustained While Wearing Elevated "Platform" Shoes

Case No. and Date of Injury	Age	Sex	Diagnosis	Treatment	Follow-up
No. 1. (6-11-73)	36	M	Posterior dislocation, right ankle. Comminuted frac- ture, lateral malleolus. Severely comminuted, fracture medial malleolus.	Open-reduction wire fixation, lateral malleolus. Short-leg cast.	Cast removed 8-15-73. Patient has returned to work.
No. 2. (8-22-73)	26	F	Displaced fractures of posterior and lateral malleous, right ankle.	Open-reduction screw fixation, posterior malleolus. Circular wiring fibular fracture. Long-leg cast.	Short-leg walking cast applied 10-9-73, removed 11-9-73. Has returned to work.
No. 3. (9-15-73)	46	F	Nondisplaced oblique fracture, right lateral malleolus.	Short-leg walking cast.	Cast removed 10-15-73. Has returned to her home duties.
No. 4. (11-2-73)	31	M	Fracture, left medial malleolus involving articular surface. Oblique fracture lateral malleolus.	Open-reduction screw fixation, and Palmer nail, medial malleolus.	Cast off on 1-10-74. Has been on crutches for the past one month.
No. 5. (11-3-73)	32	M	Nondisplaced fracture, right calcaneous with involvement of the subtalar joint. Böhler's angle is normal.	cast.	Seen on 1-28-74. Had removed cast himself. Lost to follow-up. May need subtalar fusion.
No. 6. (11-4-73)	32	F	Fracture right medial melleolus, at joint line with lateral displacement. Spiral fracture lateral malleolus.		Short-leg walking cast applied 12-17-73. Removed on 1-14-74. Residual pain.



Fig. 6. Elevated sole of the shoe results in considerable instability and, with inversion, can cause injury, even when stepping on a small stone (as shown here) or by stepping in a hole.

ground, greatly distorted by the thick soles and the high heels of the shoes. The wearer's heel slides off the "platform" shoe with any irregularity in the sidewalk, but it can also happen when the person is stepping up or down from the curb, or walking down an incline or steps. The high heels produce a greater stress in the ankle joint and give an unsteady gait to the wearer of the shoes, which requires the ligamentous structures of the ankle to carry an unusual load.

The cases in this series represent severe injuries in a relatively brief period of time which, according to each patient, were directly due to the wearing of "high shoes."

Summary

Many minor ankle and foot injuries have occurred in the past year while individuals were wearing the fashionable, elevated or "platform" shoes. This article reports six severe ankle fractures



Fig. 7. Shows eversion when in contact with any irregularity of the ground. Balance is easily lost, resulting in an eversion-type injury.

and fracture dislocations with a minimum of trauma, when the foot twisted on an uneven surface causing a sudden, severe force. The results were four fracture dislocations of the ankle necessitating open reduction and internal fixation, one undisplaced ankle fracture, and one calcaneous fracture requiring plaster immobilization. These shoes may have soles elevated as much as 4 cm and the heels 15 cm. They are worn by male and female alike. Our experience was with three males and three females whose ages ranged from 26 to 46 years. The injuries resulted in lost work time with the potential for future disability in the involved joints. Physicians and patients should be made aware of the serious potential hazards to persons wearing "platform" shoes.

Reference

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Urologic Screening at Seiberling Grade School in Akron, Ohio

A Pilot Study

Walter A. Keitzer, M.D. James S. Allen, M.D. Jack L. Summers, M.D.

A cooperative effort between the Akron Board of Education and a group of physicians specializing in urology presents interesting statistics concerning urinary tract conditions in both male and female grade school students.

THE SCREENING of school children for hearing and visual defects has been carried on for many years. These have been both productive and valuable to the general population. Screening for urologic problems has been limited and frag-

mented. Yet, the genitourinary system, as one of the most complicated embryologic systems in the body, has a high incidence of congenital defects. Many of these defects are minor and are easily overlooked, but they play an important role in the development of chronic urinary tract disease in the adult. For instance, one of the most common urologic symptoms is enuresis. It occurs in 24 percent of the boys and 18 percent of the girls at the age of 4 years and thereafter. Very little has been done to define these urologic symptoms or problems in the school child. The development of a suitable screening procedure has evolved through a series of studies. The pilot study, using the most productive elements, is the subject of this paper.

Kunin, et al¹ in 1961, made 20,000 midstream urine cultures on some 16,000 school children. An incidence of bacteriuria in 1.2 percent per year in the girls, and 2.9 percent over a two-year period, was established. They concluded that there was an overall incidence of 3.9 percent bacteriuria in female school children from the ages of 6 to 13½ years. They believed that all girls in school should be screened for bacteriuria. The increased time and expense of cultures necessitated its deletion from this pilot study. The low yield also was considered.

Our experience,2 using the physiologic voiding pattern, suggests its merit as a screening tool. From the audiograph, we could obtain the size and shape of the patterns (force of urinary stream in the atmosphere), the average flow rate, and a specimen for culture and dipstick.

Surveys

In 1964, we had the opportunity to screen 87 Boy Scouts and 37 Girl Scouts by means of the physiologic voiding pattern. The tests were conducted by a second-year medical student for the Boy Scouts, and a second-year student nurse for the Girl Scouts. In what appeared to be a healthy group of individuals, we found that at least 25 to 30 percent of them had an increased resistance to voiding which would suggest the possibility of a urologic problem. In 1965, we made a survey of 100 general admissions at the Children's Hospital of Akron, using the average voiding pattern, flow rate, and a history questionnaire. Again, there was a high incidence of abnormal patterns (50 percent). This suggested that a more thorough examination should be done. In 1968, we screened 100

student nurses who performed the test themselves using a history questionnaire, physiologic voiding pattern, average flow rate, and the urinalysis from their annual physical examination. A high incidence of abnormality (40 percent) was suggested. The urinalysis was of limited value; only one patient showed more than 1+ albumin, and 7 percent showed only a trace of albumin. There was sugar reported, and only one patient had more than 5 to 7 white blood cells (WBC) per high-power field. However, the history suggested that 24 percent of these students had previous infections or symptoms suggestive of a urinary tract infection. Only 5 percent stated that they had been treated for any urinary tract infections.

Wolin,³ used a history questionnaire for 4,211 student nurses in which he specifically inquired concerning pregnancy, coitus, history of urinary or venereal infection, and stress incontinence. He concluded that 50.7 percent of all these student nurses had experienced some degree of stress incontinence on occasion during their lifetime. The overall incidence of history of urinary tract infection was 11.1 percent in this group. The 16.2 percent who had daily stress incontinence gave an overall history of 22.3 percent having had an infection. The group was examined with midstream cultures and 47.6 were noted to have bacteriuria, while 70 percent reported symptoms of some urinary tract problem. These studies confirm the importance of a good history questionnaire and the need for midstream cultures, particularly in the female. The findings of 50.7 percent presenting with stress incontinence suggested that a urodynamic problem was present producing such symptoms. However, this does not pick up the problems in the male.

In our text on urodynamics,2 we proposed what we called the "requirements for micturitionenuresis screening of children." It would consist of the following:

- 1. A history questionnaire of at least 20 questions, not only concerning the patient but also his family.
 - 2. A routine physiologic voiding pattern.
- 3. A provocative (Urecholine®) voiding pattern for neurogenic bladder.
 - 4. Midstream culture of urine.
- 5. Dipstick test of urine for albumin and
 - 6. Microscopic sediment examination.
 - 7. Blood pressure determination.

This, of course, is the identical system we use in our office in the daily, routine practice of urology. Practically all of the testing can be done by paramedical urologic associates or assistants. Physical examination and medical opinion are rendered by the urologist. By following this outline, students at any school could be screened for uri-

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Submitted April 1, 1974.

nary tract problems with a 90 percent probability that the vast majority of the urinary tract problems would be positively screened.

In the spring of 1972, the Akron Board of Education allowed us the privilege of making a pilot study on the first-grade students at Seiberling Grade School. The provocative voiding test, microscopic examination, urine culture, and blood pressure determination were not used, mainly because of the required time and cost.

Procedure

A series of 215 consecutive first-grade children were screened in a two-day period (ten hours). The average age was 7 years, and the first grade consisted of 112 boys and 103 girls. The evaluation was performed within the confines of the school. In addition to the teachers and a school nurse, we sent three trained technicians to obtain the physiologic voiding patterns and the dipstick tests for albumin and sugar. A second-year resident in urology observed all the boys for urologic defects by simple inspection. The history questionnaire, the physiologic voiding patterns with the average flow rate and urinary dipstick, and the physical examinations were then correlated by the urologists.

Results

The history questionnaire for the children is summarized in the Table. The average age was 7 years. Nineteen percent of the boys were enuretic, as were 13 percent of the girls. If you add to this four more boys and nine girls who had stress incontinence, it makes a rather high incidence of specific urologic symptoms.

Twenty-three of the boys and 26 of the girls had a trace of albumin. The significance of this is not known. When we combine a history questionnaire with the physiologic voiding pattern, particularly those showing the decompensated-type of bladder pattern, we would have to consider that 36 percent of the boys and 39.9 percent of the girls had a potential for urinary tract problems.

Confirming this to a large extent was the inspection of the boys by the urology resident, who noted that 19 percent of the boys had a pinpoint meatus. Five other boys had an equivocal stenosis of the meatus, which would have to be calibrated in order to be certain. This high incidence of unrecognized meatal stenosis is consistent with our finding in newborns.⁴ Six of the boys had undescended testicles which probably should have been repaired before they reached school age. Three of the boys had hypospadias, one of which was second degree and, again, probably should have been repaired before school age. One of the boys had a hydrocele which, at his age, indicates an indirect

Questionnaires for Seiberling School Children First Grade Average Age — 7 Years

	History Revealed	Females	Total No. Males	
		103	113	
1.	Treatment of			
	urinary tract disease	18	6	
2.	Pus in urine	16	8	
3.	Sugar in urine		0	
4.	Albumin in urine	3 8	0 3 8 1	
5.	Kidney or bladder x-rays	10	8	
6.	Blood in urine	5	1	
7.	Family history of kidney defect	t 6	4	
	Swelling of			
	eyelids, hands, and feet	4	5	
9.	Unexplained fever	5	4 4 17	
	Pain in loin or abdomen	4	4	
11.	Enuresis or bedwetting	13	17	
12.	Stress incontinence	4 5 4 13 9 5 5	4	
13.	Frequency of urination	5	6	
14.	Infrequent voiding	5	2	
15.	Urethral or vaginal discharge		2	
16.	Strain to void	6	3	
17.	Burning on urination	11	2	
18.	Difficult to stop voiding	4	4 6 2 2 3 2 1 1	
19.	Pain in the groin	1	1	
20.	Interrupted stream	0	2	

inguinal hernia until proven otherwise. Thus, by inspection alone among the boys, over 25 to 30 percent showed evidence of a potential urinary tract problem.

In those children that a potential problem was suggested, a letter was sent to the parent by the school principal. Follow-up as to the true correlation with the pathology and the clinical impression of the child's physician was less than ideal. Since we remained anonymous throughout the study, the only adequate follow-up was with the limited number of children filtering into our urologic office and the personal communication with the two pediatricians practicing in the immediate geographic area of the "screened school."

Conclusions

We feel that the known high incidence of urinary tract defects makes it one of the most worthwhile screening areas for any group of school children. Our pilot study substantiated this high incidence of urologic problems, particularly those "mild abnormalities" associated with the lower urinary tract. The feasibility of such screening is now proven in our minds. With the added experience of several additional sessions and with the gained expertise, we feel that the screening of school-age children can be economical and can be performed with little disruption of the school day. A complete follow-up is recognized as essential to better equate the false positives with our techniques. A urine culture and coordination with the

public health department are contemplated for a more comprehensive program.

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MATERNAL HEALTH IN OHIO

Choriocarcinoma of the Placenta

By the OSMA Committee on Maternal Health*

THE OSMA MATERNAL MORTALITY Study Committee presents a brief educational summary with clinical therapeutic review of specific problems associated with the pathology of the placenta involving a malignancy. Physiologic invasion of the maternal tissue (decidua) by the fetal (placental) tissue is accepted as normal. At the same time, it has been demonstrated that placental growth may or may not be dependent upon the presence of the fetus. Degenerative changes or "fibrinoid degeneration" of the "Nitabuch's layer" is associated with "placenta accreta." A further degenerative condition is the "placental infarct," described by some as the "ischemic necrosis of villi due to fibrin deposition." Formation of cysts and calcification of the placenta are associated with this condition.

Tumors or new growths of the placenta are usually placed in the following four categories: (A) hemangioma, (B) squamous metaplasis of the amnion, (C) hydatid mole, and (D) a very malignant tumor — the "chorioepithelioma," or "choriocarcinoma" or "deciduocellular sarcoma."

The Committee presents the findings involving three disease entities associated with "chorioepithelioma." During the period from 1955 to 1971, the Committee has studied approximately eight patients who were afflicted with this devasting disease.

Missed Abortion and Dilatation and Curettage

The patient was admitted to a hospital with a history of profuse vaginal bleeding of 24-hour duration and a weight loss of 22.7 kg (50 lb) during the previous three months. On admission, her temperature was 38.3 three months. On admission, her temperature was 38.3 C (100 F), pulse rate 140 beats per minute, hemoglobin reading 9.7 gm/100 ml, and white blood cell count (WBC) 8,242/cu mm. Result of pregnancy test was positive. Serum gonadotrophin level was greater than 1,000 mouse units. Chest x-ray revealed five diffuse nodular lesions of 1 to 5 cm in diameter.

The patient thought she was approximately eight-months pregnant; she had had one prenatal visit at ap-proximately three-months' gestation. The patient stated she had had an incomplete abortion followed by a dilatation and curettage approximately 11 months prior to her present admission. She stated she had a normal term pregnancy with vaginal delivery approximately three years prior to this admission and a stillbirth several years before the term pregnancy.

Clinical examination revealed a uterus of approximately five months' gestation and a cervix dilated to 3

Following six hours of Pitocin® infusion without success and continuous vaginal bleeding, a dilatation and curettage was performed. Pathologic diagnosis of currettings was reported as "choriocarcinoma." Patient received supportive treatment including five blood transfusions. Seven days following the dilatation and curettage, an abdominal hysterectomy and bilateral salpingo-oophorectomy were performed. The immediate post-operative course was complicated by ileus. The pathologic diagnosis was "choriocarcinoma with metastasis to left ovary and invasion of uterine wall."

Methotrexate therapy was instituted on the tenth post operative day. The patient died 20 days following the dilatation and curettage (13 days following hysterec-

tomy).

Cause of Death (Autopsy): (1) Choriocarcinoma of the uterus with metastasis to the lungs, left ovary, and vagina; (2) cardiac hypertrophy with cardiac failure; (3) pulmonary edema; and (4) hyperthyroidism.

Comment

The Committee noted the patient's failure to avail herself of adequate prenatal care. Chorio-

^{*}A continuous statewide Maternal Mortality Study is being conducted by the Committee on Maternal Health of the Ohio State Medical Association in cooperation with the Ohio Department of Health and representatives of the various County Medical Societies. Discussions of some of the cases studied by the Committee, based on anonymous data submitted, are published here from time to time, interspersed with statistical reports.

epithelioma (choriocarcinoma) may be responsive to the therapeutic chemical agents now available.

Abnormal Intrauterine Pregnancy of an Adolescent

The patient, an adolescent, was admitted to a hospital with a diagnosed pelvic-abdominal mass extending two to three fingerbreaths above the umbilicus. She denied having had intercourse (coitus); a pregnancy test was reported positive. Hemoglobin level was 10.4 gm/100 ml and WBC was 9,400/cu mm. Examination under anesthetic revealed the uterus to be approximately the size of a three-month gestation. Menstrual history was irregular. She had a two-day menstrual period approximately two months prior to hospital admission with a regular menstrual period reported one month prior to this two-day period

The patient was discharged from the hospital and allegedly sought an abortion in another state, only to be rejected as being too far advanced in her pregnancy. She returned to her home and sought a therapeutic abortion

and psychiatric counseling.

Two weeks after the original hospital admission, she was readmitted to hospital with nausea and vomiting. The fundus was now stated to be at the level of the umbilicus. Her temperature was 37.3 C (99.2 F); blood pressure 120/70 mm Hg; pulse rate 152 beats per minute; respirations 28 per minute; WBC 28,600/cu mm; hemoglobin level 9 gm/100 ml; urine values: red cells 14 to 16 million, white cells 3 to 5 million, and protein 20 mg. Intravenous pyelogram revealed dilated collecting system and ureters. Barium enema revealed displacement of colon with intrinsic invasion of the colon by a tumor mass. Lateral chest x-ray showed multiple nodules in both lung fields, assumed to be metastatic lesions. On the day after admission, moderate jaundice of sclera and skin were noted. Hemoglobin level dropped to 5 gm/100 ml with no visible vaginal or rectal bleeding.

The patient was given supportive therapy including four blood transfusions. A quantitative chorionic gonadotrophin test showed 138,240 units/24 hours.

A diagnosis of choriocarcinoma of the uterus with metastasis to the sigmoid colon and lungs was made. Intravenous methotrexate therapy was instituted.

The patient died two weeks after the second hos-

pital admission.

Autopsy examination was denied by the family.

Cause of Death (Certificate): Choriocarcinoma of the uterus with generalized metastases.

Comment

The Committee noted the delay incurred as the patient and her family sought unsuccessfully to have an abortion performed. The institution of the methotrexate therapy might have been more effective at an earlier date. The Committee finds that early diagnosis is critical in the treatment of a disease of this type.

Repeat Cesarean Section with Ischemic Necrosis of Villi Due to Fibrin Deposition and Calcification of the Placenta

This patient was admitted to a hospital with severe abdominal and pelvic pain, shock, no vaginal bleeding, and a provisional diagnosis of ruptured ectopic preg-

One month prior to hospital admission, the patient had a positive pregnancy test; she had had no menstrual period for six weeks. Uterus was within normal limits, and result of Papanicolaou's test was negative. She had been taking oral contraceptives for four months. This therapy had been instituted one month post partum following a repeat cesarean section at term which was per-formed six months prior to present admission. The placenta was reported to have presented heavy calcium

deposits.

Surgery was performed immediately following admission. Free blood was found in the peritoneal cavity coming from the (ruptured area) left cornu of the slightly enlarged uterus. Total hysterectomy was performed. Pathologic diagnosis was "choriocarcinoma of the uterus with tumor emboli seen in the myometrial ves-

The patient received supportive treatment including four units of whole blood. On the second postoperative day, she developed bilateral bronchopneumonia with a question of septic embolization. Chest x-ray examination confirmed the diagnosis of bilateral bronchopneumonia. The patient was transferred to the intensive care unit of a second hospital. She died 20 hours after admission to that hospital.

Cause of Death (Autopsy): Choriocarcinoma of uterus with metastasis to lungs, pancreas, kidneys, spleen,

and vagina.

Comment

The Committee noted the pathology of the placenta at time of the cesarean section, the contraceptive therapy, and the positive pregnancy test. and believes the correlation of multiple clinical findings is important. Chemotherapy was not available due to the time interval involved in making the clinical diagnosis of chorioepithelioma.

Comment of Consultant

The following Comments of a Consultant, who is a gynecologic pathologist, were furnished at the request of the Committee:

"In the case in which a definite diagnosis of choriocarcinoma can be made on curettings, current therapeutic opinion for a young patient would tend to favor a primary course of chemotherapy (methotrexate and/or occasionally other agents such as actinomycin D and vincaleukoblastine) with hysterectomy necessary only if there was a continuation of the massive hemorrhage or a persistence of high titers of chorionic gonadotrophin following chemotherapy.

"Factors other than the extent of the tumor appear to be important in the direct cause of death in the patient (marked hyperthyroidism with associated cardiac hypertrophy and cardiac failure with pulmonary edema with the additional stress of a postoperative peritonitis and ileus).

"Quantitative titers of chorionic gonadotrophin should be requested whenever there is a marked disparity in the clinical history and the physical findings. Often a strong presumptive indication of trophoblastic disease may be obtained even before a definitive tissue diagnosis is obtained.

"The adolescent patient demonstrates well the rapidity of growth of some phases of choriocarcinoma. When first seen only 21/2 months after her last normal menstrual period, there was an abdominal mass above the umbilicus. In four weeks, death ensued with involvement of three of the most common sites of spread of this aggressive tumor,

with clinical evidence of metastases to the lungs and liver, and with direct extension of the tumor through the myometrium into the parametrial structures and colonic wall.

"In still another instance, coagulation necrosis and hemorrhage are almost constant microscopic features of invasive choriocarcinoma. These features are responsible for the frequent initial clinical symptoms of internal (intra-abdominal or pulmonary) or external (uterine or vaginal) hemorrhage.

"The spread of the tumor is predominantly through vascular channels rather than by lymphatics which explains the multiplicity of metastatic sites in some patients dying of choriocarcinoma.

"General Comments: Choriocarcinoma remains an important, though uncommon, cause of maternal deaths. Considerable progress has been made in the management of this aggressive tumor which was formerly almost always fatal.

"Major advances have been made in the areas of increased sophistication and sensitivity of the laboratory procedures for the determination of chorionic gonadotrophin titers. These tests are helpful both in the initial diagnosis of trophoblastic disease and as the best method of detection of residual or recurrent tumor following chemotherapy. For the latter, concentration techniques or the use of the highly sensitive radioimmunoassay methods may be necessary to detect small but significant increases in gonadotrophin levels which had been undetectable with convential methods.

"A dramatic change in the prognosis of trophoblastic disease has followed the use of newer forms of chemotherapy. In the three disease entities presented, the patients were treated with courses of methotrexate, but none received a full course of therapy adequate to evaluate the tumor response to the drug. Current reports indicate a remission rate of up to 60 percent in cases of choriocarcinoma and 75 percent in cases of invasive hydatid mole and chorioadenoma destruens.

"A high clinical index of suspicion is always a requirement for the early diagnosis of this disease."

Emergency Phone Prescription for Schedule II Drugs

In a bonafide emergency, a physician may telephone a prescription order to a pharmacist for a Schedule II drug. A recent edition of the Drug Enforcement Administration's publication contained the following guidelines for physicians:

1) The drug prescribed must be limited to the amount needed to treat his patient during the

emergency period;

2) Prescribing or dispensing beyond the emergency period must be pursuant to a written prescription order;

3) The dispensing pharmacist must reduce

the oral request to writing;

4) The pharmacist has responsibility to make reasonable effort to verify the order when the physician is unknown to him;

5) The physician is required to furnish, within 72 hours, a written signed prescription order to the pharmacy for the drug prescribed; and

6) The pharmacist is required by law to notify DEA should he not receive the written signed prescription order within the 72 hours. "Emergency" means that:

1) Administration of the drug is necessary for proper treatment;

2) No alternative drug is available, and

3) It is not possible for the physician to provide a written prescription for the drug at that

Self-Dialysis at VA Centers

Continued expansion of Veterans Administration facilities for treating veterans with kidney disease is planned during the current fiscal year. With approximately 20 percent of the nation's hemodialysis capability, the Veterans Administration will have self-dialysis with minimal supervision available at each of its 51 centers this year.

The Veterans Administration has 24 additional dialysis sites where patients, whose home living arrangements will not accommodate the equipment, can use the artificial kidney machine. Home dialysis for approximately a thousand veterans is furnished and 16 university-VA affiliated kidney transplant centers provide the surgery so often necessary among patients with chronic kidney failure.

Because kidney disease is considered the fourth major cause of death in the United States, Veterans Administration medical officials are actively promoting cooperation between Veterans Administration and non-VA medical facilities to bring about sharing of the expensive dialysis services on a regional basis.

Professional Cativities

Proceedings of The Council

Meeting of February 1-2, 1975

A REGULAR MEETING of the Council of the Ohio State Medical Association was held Saturday and Sunday, February 1 and 2, 1975, at the Columbus Headquarters' Office, 600 S. High Street, Columbus, Ohio.

Those present Saturday were: All members of the Council; Mr. James E. Pohlman, Esq., Columbus, OSMA Legal Counsel; Mrs. Mary T. King, Columbus, Student AMA Representative; Dr. John H. Ackerman, Columbus, Director, Ohio Department of Health; Dr. Timothy B. Moritz, Columbus, Director Designate, Ohio Department of Mental Health and Mental Retardation; Drs. Harry K. Hines, Cincinnati; Robert N. Smith, Toledo; Richard L. Fulton, Columbus; Jerry L. Hammon, West Milton, and William R. Schultz, Wooster, all members of the Ohio Delegation to the AMA; and Messrs. Page, Edgar, Gillen, Campbell, Clinger, Rader, Houser, Holcomb, Mulgrew, Mrs. Wisse, Mrs. Dodson and Mrs. Tanner, of the OSMA Staff.

Those present Sunday were: All members of the Council (with the exception of Dr. Thomas W. Morgan); Mr. Pohlman; Dr. Richard Ruppert, Columbus, Vice Chancellor for Health Affairs, Board of Regents, and all members of the OSMA Staff (with the exception of Mrs. Tanner).

The meeting was called to order by President Henry.

The minutes of the December 14-15, 1974 meeting of the Council were approved.

Membership

Membership statistics were presented by Mrs. Wisse and were accepted for information.

Letters from Drs. James L. Fisher and R. A. Bacani, both of Youngstown, were presented for the information of the Council.

Fiscal Matters

The minutes of a meeting of the Committee on Auditing and Appropriations held February 1, 1975, were presented by Dr. Bates.

The Council, in accordance with the recommendations of the Committee approved: a reduced rate in *The Ohio State Medical Journal* for an advertisement of the Toledo Law Review colloquium.

The Council also **approved** an appropriation of \$2500 for furniture and record files and approximately \$300 for "panic door hardware" on the front door of the headquarters' building.

A request for a contribution to the Rardin Endowment fund was deferred until more particulars were obtained for study. A request for funds to support the physician's office in the Ohio Village was deferred to permit discussion with the Ohio Osteopathic Association of Physicians and Surgeons and the Woman's Auxiliary to the Ohio State Medical Association.

The Council unanimously approved the following resolution:

"WHEREAS, many members of OSMA have contributed substantial time and effort in developing the medical criteria and other components of the MAI Peer Review System (PRS), and

"WHEREAS, MAI has entered into a contract with the Ohio State University Research Foundation (OSURF) for assistance in the further development of the MAI PRS, and

"WHEREAS, MAI does not have sufficient funds at the present time to pay OSURF for completion of the project developing the MAI PRS, and

"WHEREAS, the Council of the OSMA believes that the completion of the MAI-OSURF development contract would not only be in the (Continued from page 147)

best interests of the members of the OSMA to preserve the efforts of those who have contributed to the MAI PRS, but would also be in the best interests of the people of the State of Ohio, by enhancing the quality of medical care received by them, now, therefore, be it

"RESOLVED, That the Council of the OSMA approve a loan to MAI in the amount of \$12,500 to be evidenced by a promissory note, dated February 1, 1975, payable in 6 months and bearing interest at the rate of 9%."

The minutes, as a whole, were approved.

American Medical Association

The report of the meeting of the AMA Delegation, held January 31, was presented by Dr. Clarke. The Council adopted a resolution commending Dr. Richard L. Meiling for his leadership of the Delegation as Chairman since 1970. The Delegation presented the following slate of officers as nominees: Dr. P. John Robechek, Chairman, and Dr. Oscar W. Clarke, Vice Chairman. By official action, the nominees were elected by the Council.

In answer to a question from the Delegation, the Council adopted the policy that delegates and alternate delegates, representing Ohio in the AMA Delegation, must be members of the American Medical Association, in accordance with Chapter 9, Section 3, of the Bylaws of the American Medical Association.

The \$60 assessment voted by the House of Delegates of the AMA, in Portland, was discussed.

With regard to objectives of the AMA, it was the expression of the Council that the promotion of the health of the public remain in the objectives of the AMA and that the Association "work toward enriching the quality of life" as an objective.

With regard to the question as to the powers of the House of Delegates and of the Judicial Council, the Council expressed the opinion that the ultimate authority of the Association should rest with the House of Delegates.

The report of the AMA Delegation Study Committee was reviewed by the Chairman, Dr. William R. Schultz.

Annual Meeting

A progress report on the 1975 OSMA meeting was presented by Mrs. Dodson.

The Council voted that a program on the professional liability crisis be presented at 1:00 p.m., Monday, during the Annual Meeting.

Ohio Medical Indemnity, Inc.

Dr. Oscar W. Clarke reported on the January 22 meeting of the Board of Directors of Ohio

Medical Indemnity, Inc. The report was received for information.

Ohio Foundation for Medical Care

The minutes of the Board meeting of the Ohio Foundation for Medical Care, held January 15, were presented by Mr. Houser for information.

Ohio Director of Health

A special guest of the Council was Dr. John H. Ackerman, Columbus, Director of the Ohio Department of Health, as appointed by Governor James A. Rhodes. Dr. Ackerman expressed strong belief in the traditional responsibilities of the Ohio Department of Health in the field of public health and preventive medicine. Dr. Ackerman stated to the Council that "my feeling is that we can do it together. We must have contact. Call me at any time."

Professional Liability

The minutes of the Committee on Insurance meeting of January 22, 1975, were presented by Mr. Campbell. The Council approved a recommendation of the committee that Johnson and Higgins be authorized to conduct a feasibility study with regard to the advisability of a sponsored professional liability insurance plan in Ohio. The remainder of the report was accepted for information.

The Council then adopted the following short and long range programs to deal with professional liability problems.

Short Range Program:

1. The OSMA program which assists in obtaining professional liability coverage for physicians who have lost their insurance and which assists in obtaining coverage for new physicians entering practice in Ohio is to be continued.

2. Officers and staff of the Association were asked to continue to work closely with the Ohio Department of Insurance in problem-solving operations in the areas of cost and availability of professional liability insurance.

3. The officers and the staff were instructed to continue their work with the officers and staff of the Ohio State Bar Association in working out solutions to the professional liability crisis.

4. The officers and staff were directed to continue their work with the officers and staff of the Ohio Hospital Association and the Ohio Osteopathic Association of Physicians and Surgeons and related groups in a mutual effort to solve mutual concerns in professional liability.

5. The officers and staff were directed to make a formal approach to the medical specialty societies in Ohio, offering assistance and asking for a unified program on professional liability.

Long Range Program:

- 1. The Association will cooperate with the Ohio Department of Insurance in a "five group consortium."
- 2. Legislative programs will be initiated in cooperation with the consortium.
- 3. Legislative priorities were established as follows:
 - (a) Commission Plan.
 - (b) Binding Arbitration.
 - (c) Informed Consent Forms.
 - (d) Amendment of Statute of Frauds.
- 4. In light of the feasibility study approved above, the Council voted not to be involved with establishing its own professional liability company at this time.

Committee Reports

Committee on Government Medical Care Programs

The minutes of the Committee on Government Medical Care Programs meeting of January 8, were presented by Mr. Houser and were received for information.

A Peer Review Systems Council review of the Nationwide Insurance Company's Post Payment Review Program was discussed and tabled until the matter has been discussed with the county medical societies.

Commission on Education

The minutes of the Commission on Education meeting of January 15, were presented by Mr. Edgar and were referred back to the committee for clarification on the matter of continuing medical education credits prior to 1975.

Ad Hoc Committee on Complaint Procedures

The January 15 minutes of a resource group providing advice to the Ad Hoc Committee on Complaint Procedures were presented by Mr. Campbell.

Committee on Maternal Health

The minutes of the Committee on Maternal Health meeting, held January 18-19, were presented by Mrs. Dodson and were accepted for information.

Ad Hoc Committee on Constitution and Bylaws Revision and Professionalism

The minutes of the Ad Hoc Committee on Constitution and Bylaws Revision and Professionalism meeting of January 19, were presented by Dr. McLarnan. The Council approved resolutions on "Student Membership" and "Fiscal Notes for Resolutions Involving Expenditures of Money"; a recommendation against establishing the office

of Speaker of the House, and the progress report on policies with regard to screening programs. The report was accepted as submitted.

Council Fee Review Committee

The report of the Council Fee Review Committee meeting of January 31, was presented by Mr. Campbell. With regard to the question of a Blue Cross case, as to its designation as custodial or non-custodial care, it was requested by the Council that additional information be obtained.

Committee on Public Relations

The minutes of the Committee on Public Relations meeting of January 29, were presented by Edgar and were accepted for information only.

Director of Mental Health and Mental Retardation

Dr. Timothy Moritz, Governor James A. Rhodes' Director Designate of the Ohio Department of Mental Health and Mental Retardation, addressed the Council. Dr. Moritz told the Council that the task before him includes action to improve the amount and quality of professional staff in his department. The focus of his attention in the long range, however, will be the build-up of community based systems of care with increased involvement of the voluntary sector. This, he believes, is an effective alternative to institutional care and the general socialization of the Mental Health Program. He emphasized the fact that physicians should be in control of admission, treatment and discharge of mental patients and asked the cooperation of the medical community.

State Legislation

Mr. Rader reported on state legislation and the Council acted as noted on the following bills:

H.B. 50—Places a lay member on each professional licensing board — opposition.

H.B. 79, H.B. 147 and S.B. 68—Licenses audiologists and speech pathologists — no opposition, if properly amended. (Drs. Gaughan and Clarke "nay.")

H.B. 229—Establishes osteopathic medical school — under study.

S.B. 2—Protects privacy of computer records — under study.

S.B. 75—Establishes separate chiropractic board — active opposition.

The Council approved a policy endorsing a sliding scale of fees for professional licensing Boards, up or down, in accordance with operation of the Board.

Constitution and Bylaws

Amendments to the Constitution and Bylaws

(Continued from page 149)

of the Lake County Medical Society were approved as submitted.

Legal Counsel Report

Mr. Pohlman discussed the desirability of having all county societies adopt the "model" Constitution and Bylaws. The Council voted to encourage strongly the adoption of the "model" Constitution and Bylaws by those societies that have not yet done so and asked that such model be completed for each such individual county society and that the Department of Field Service assist in their adoption.

Mr. Pohlman was requested to advise the Council on proper handling of the Committee on Maternal Health reports, in order that future legal problems can be avoided.

Field Service Report

Mr. Holcomb presented a report that liaison and assistance was given by field service to 16 different counties with a total of 20 visitations. There was direct participation in 7 county medical society meetings and one special meeting for professional liability. Athens, Erie, Allen, Wayne, Carroll, and Guernsey Counties were given administrative assistance.

A request was made for input to update and revise the county reference handbook.

Ohio State Medical Journal

A report on *The Ohio State Medical Journal* was presented by Mrs. Tanner and was accepted.

Harrison County Matter

The Harrison County matter was discussed by the Council. Legal Counsel advised that the matter of discrimination against some members of the medical community, by furnishing office space without charge to other members of the medical community, could constitute a rather difficult problem. The District Councilor and Mr. Page were authorized to discuss the matter with the local society.

Spring Councilor District Conferences

Spring Councilor District Conferences were discussed. It was felt that possible conferences on professional liability problems might be necessary and that they be optional with timing to be determined by the President.

Correspondence from Nationwide

Correspondence involving obscenities in connection with the filing of Medicare information was referred to the county medical society.

Dr. Richard Ruppert

Dr. Richard Ruppert, Vice Chancellor for Health Affairs, Board of Regents, appeared before the Council and asked the Council for comments concerning the Health Manpower Program. He outlined the following problems in health manpower education:

"1. Shortage of physicians.

as follows:

"2. Shortage in Family Health Care.

"3. Maldistribution of health professionals.

"4. Keeping up with the knowledge explosion. "5. Access into the health profession by mi-

norities and disadvantaged."

His goals in manpower health education were

"1. Retention of Ohio's Medical Graduates.

"2. Increase Physicians in Primary Care.

"3. Coordination of Continuing Health Manpower Education.

4. Establish Special Recruitment and Development Program."

He discussed his approach to medical student education loans, the priorities on minorities and disadvantaged, financial need and primary care with options for loan cancellation of one year practice for one year loan. He also discussed primary care residencies for general internal medicine, general pediatrics, and family practice—these loans to be worked off on a one year basis for each one year loan.

Dr. Ruppert also discussed the implementation of H.B. 474.

Contribution from A. H. Robins Company

The Council expressed its thanks to A. H. Robins Company for funds donated to the Association and asked that the contribution be turned over to the Committee on Auditing and Appropriations for proper distribution.

Executive Session

The Council went into closed session, then subsequently reconvened in regular session.

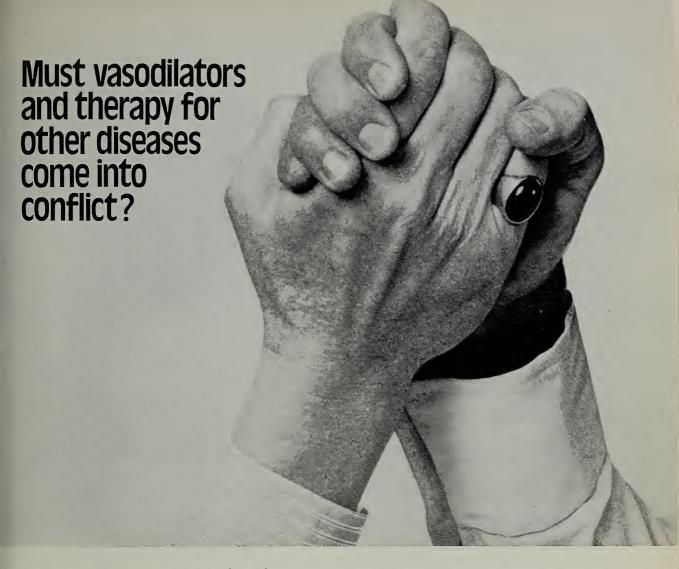
Peer Review Resolution

The Council voted to consider a resolution clarifying the Association's position on peer review and instructed staff and Legal Counsel to prepare a draft resolution to be presented to the Council for consideration at the next meeting.

Redistricting Request

In answer to a request from the Summit County Medical Society, the President appointed, and the Council **approved**, the following ad hoc committee, and charged it with investigating the possibility of redistricting of the Sixth Councilor District: Dr. McLarnan, Chairman; Drs. Gaughan, Rinderknecht and Thomas.

Adjourned. ATTEST: Hart F. Page Executive Director



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In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

- For the relief of symptoms associated with cerebral vascular insufficiency.
- 2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
- 3. Threatened abortion

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCI, 10 mg. and 20 mg. Dosage and Administration: 10 to 20 mg. three or four times daily. Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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Meading LABORATORIES

AMA To Sponsor Conference On Disabled Physicians

Alcoholism, drug dependence and mental disorders existing in the physician population will be the major theme of a national conference on the "Disabled Physician," April 11-12, sponsored by the American Medical Association.

Malcolm Todd, M.D., president of the AMA, calling the conference a "landmark meeting," stated: "Now is a critical point in medical history for us to assume and exercise our full responsibility in providing competent care to patients."

Meeting at the St. Francis Hotel in San Francisco, the conference will attract some 300 medical authorities representing various specialties. Participants will examine the motivational aspects, as well as appropriate mechanisms, for encouraging doctors with these disabilities to seek advice and treatment.

Accented during the two-day meeting will be accountability to the public through the assurance of competent patient care. Conference speakers and attendees will explore alternative formal and informal procedures for the effective treatment, rehabilitation and disciplinary action, when necessary, of the disabled physician.

The role of the medical society, relationships with state licensing bodies, and legislative support mechanisms will be other areas of discussion. The program features workshops on treatment modalities, treatment facilities and physician re-entry into professional life.

Also, a discussion session will be devoted to practical ways of implementing AMA's model legislation, the "Disabled Physicians Act," which takes the form of a uniform state law. Preventive rather than punitive in nature, this draft bill would establish the state medical society as an agent to the state licensing body in this particular problem area. Failing other more informal procedures, the model legislation provides for restriction, suspension or revocation of a practitioner's license for reasons arising out of physical or mental illness, including drug dependence and alcoholism.

Highlighting the roster of speakers at this conference are: Malcolm C. Todd, M.D., president, American Medical Association; Herbert C. Modlin, M.D., director of preventive psychiatry, Menninger Foundation; Stanley E. Gitlow, M.D., clinical professor of medicine, Mt. Sinai School of Medicine; LeClair Bissell, M.D., chief of Smithers, Roosevelt Hospital, N.Y.; Ron Catarazzo, M.D., Palm Beach Institute; and Ernest T. Livingstone, M.D., chairman, AMA's Council on Legislation.

Further information on the conference is available through AMA's Department of Mental Health, 535 N. Dearborn St., Chicago, Illinois 60610.

IMPORTANT INFORMATION: This is a Schedule V substance by Federal law; diphenoxylate HCI is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCI) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN, THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCI may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCI is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropinie; use with caution in children since signs of atropinism may occur even with the recommended dosage.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

Dosage and administration: Lomotil Is contraindicated in children less than 2 years old. Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) 5 times daily: adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCI with 0.025 mg. of atropine sulfate. Liquid, 2.5 mg. of diphenoxylate HCI and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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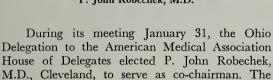
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Ohio Delegation to AMA Holds Elections



P. John Robechek, M.D.





Oscar Clarke, M.D.

President of the Ohio State Medical Association is also co-chairman of the delegation. Oscar W. Clarke, M.D., Gallipolis, was elected vice-chairman of the delegation during the same meeting.



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The

Federal

Legislative

Scene

Some say it is a "Health Legislation Package" now being introduced in Congress. It is a well-designed, stepby-step program designed to ultimately achieve the enactment of "compulsory national health insurance." Such health insurance may not be enacted until 1976 but the supporting legislation is being presented now.

Following closely upon enactment of the National Health Policy, Planning and Resources Development Act of 1974, and sequential thereto, Congressman Paul G. Rogers (D-Fla.), Chairman of the House Subcommittee on Public Health and Environment, introduced the following five bills early this year.

- 1) H.R.2956 The Health Manpower Act Similar to H.R.17084 passed by the House in 1974 and S3585 passed by the Senate in 1974 but killed in the Conference Committee. Hearings began February 20-21, 1975 on this new bill.
- 2) H.R.2954 Health Revenue Sharing and Health Services Act A similar bill was vetoed by the President in 1974 by pocket veto.
- 3) H.R.2957 The Nurse Training Act A similar bill was vetoed by the President in 1974 by pocket veto.
- 4) H.R.2955 The Development Disability Amendments
- 5) H.R.2958 National Health Service Corps Extension

In the Senate, Senator Daniel Inouve (D-Hawaii) introduced S-215, the National Medical Injury Compensation Insurance Act of 1975. Senator Edward Kennedy (D-Mass.) introduced S-482, the National Medical Malpractice Insurance and Arbitration Act of 1975. Both bills provide review by PSRO's, fees established by the federal government, licensure and re-licensure requirements as prescribed by the Department of Health, Education and Welfare, etc. Hearings on both bills are scheduled for mid-March.

An informed citizenry is a concerned electorate. Be informed. Be concerned. Know how your congressman and senator vote.

The patient with gastritis:

another type for Tylenol analgesic tablets



When the gastritis patient has a condition requiring an analgesic, a new problem arises. Aspirin's irritating effect on the gastric mucosa is well documented. 1-3

TYLENOL analgesic tablets, on the other hand, are unlikely to cause local irritation.^{2,3} which is why they are preferred in the patient subject to gastritis.

This is only one of several 'types for TYLENOL' analgesic tablets—that is, patients who should avoid aspirin. Considering all of them, wouldn't it provide added safety (as well as added convenience) to recommend TYLENOL tablets routinely for simple analgesia?

References: 1. Muir, A., and Cossar, I. A.: Brit. Med. J. 2:7-12 (July 2) 1955. 2. Vickers, F.N.: Gastroint. Endosc. 14:94-99 (Nov.) 1967. 3. Roth, J.L.A.: Med. Clin. North Amer. 41:1517-1537 (Nov.) 1957.

Precautions and Adverse Reactions: If a rare sensitivity reaction occurs, the drug should be stopped. Acetaminophen has rarely been found to produce any side effects.

Supplied: Tablets, 325 mg. For Children: Elixir, 120 mg./5cc. (alcohol 7%). Drops, 60 mg./0.6cc. (alcohol 7%). Chewable Tablets, 120 mg.

Safer than aspirin, yet just as effective for relief of pain and fever

TYLENOL acetaminophen tablets

The Professional Liability Crisis

The leadership of the Ohio Legislature is aware of the growing crisis of increasing costs and lessening availability of professional liability (malpractice) insurance in Ohio. The staff of OSMA's Department of State Legislation approached the leadership of both parties in the House and the Senate, asking each of the individuals involved to prepare a statement concerning professional liability insurance for The Journal. The resulting

four statements are from: Vernal G. Riffe, Jr. (D-New Boston), Speaker, Ohio House of Representatives; Charles F. Kurfess (R-Bowling Green), Minority Leader, Ohio House of Representatives; Oliver Ocasek (D-Northfield), President Pro Tempore, Ohio Senate; and Michael J. Maloney (R-Cincinnati), Minority Leader, Ohio Senate. The bi-partisan concern of these legislative leaders will hopefully bring concerted action when legislation is introduced.



Statement by House Speaker Vernal G. Riffe, Jr.

"The Legislature recognizes that malpractice suits against doctors have become more common and awards have grown increasingly larger. Consequently, doctors have had to protect themselves by purchasing malpractice insurance at an extremely high premium. This has resulted in higher medical costs for most Ohioans.

It is my hope that this General Assembly will be able to address itself to this problem in a forthright and responsible manner. Good health care at a reasonable cost for all Ohioans is something we must continually strive for."



Statement by Senate President Pro Tempore Oliver Ocasek

"Fundamental questions relative to professional liability in malpractice suits highlight the need for updating Ohio Statutes governing the medical profession. We in the General Assembly recognize this need and will work toward such solutions."

Statement by House Minority Leader Charles F. Kurfess, Jr.

"As a veteran of the Ohio Legislature, I have been in a position to witness the growing problem of medical malpractice and soaring malpractice insurance fees that have hit the profession in recent years.

I understand that one unfortunate result of the problem is a serious lack of malpractice insurance coverage. Some new doctors are not able to obtain coverage. Many others already in established practice have found it necessary to pay tremendously increased insurance rates.

I am especially concerned because I see those sharply increased insurance costs added to the medical bills of people who are struggling to make ends meet in difficult economic times.

This problem afflicting our health system is one I intend to continue to watch closely."

Statement by Senate Minority Leader Michael J. Maloney

It is becoming obvious that there is a problem in the area of the growing cost of malpractice insurance in Ohio and throughout the country. I personally feel that the issue is vital enough to demand close scrutiny by the members of the Ohio General Assembly, particularly in view of the possible impact of such costs on the availability of quality health care in our state."





The officers and staff of the Ohio State Medical Association held discussions with Mr. Harry Jump, Director of the Ohio Department of Insurance, on January 30, 1975. On the next day, a meeting was held with members of the Ohio Bar Association. Both discussions concerned the rapid deterioration of the Professional Liability Insurance market in Ohio.

As a result of these and other consultations, Ohio physicians can be assured of the official and personal interest of the state Executive, Legislative, and Judicial Branches in finding solutions to this critical and perplexing socio-economic problem.

Mr. Jump, through the Department of Insurance, is currently coordinating discussions and proposed remedial activities concerning professional liability insurance. This involves the OSMA, Ohio Osteopathic Association, Ohio Insurance Carriers, Ohio Bar Association, and Ohio Hospital Association. From this joint attack on the malpractice

crisis, corrective legislative proposals will be forth-coming.

Ohio physicians should send their personal or group proposals to OSMA Headquarters, 600 S. High St., Columbus 43215. Each specialty, medical society, or group is invited to join in this unified approach to the proposed legislation introduced in the Ohio House and Senate.

House Bill 229 (Fries, D-Dayton.)

This bill proposes the establishment of a College of Osteopathic Medicine in Ohio, with no location specified. The OSMA has the bill's financial and educational considerations under study.

Senate Bill 75 (Headley, D-Barberton)

This bill proposes the establishment of a separate Board to license chiropractors. OSMA is strongly opposed.



At the end of January, officers and staff members of the Ohio State Medical Association met with officers and staff of the Ohio State Bar Association to discuss the present professional liability crisis. Participating in the meeting were: (seated left to right) Daniel Rosenthal, President-Elect of Ohio State Bar Association; James L. Henry, M.D., OSMA President; William L. Howland, President of Ohio State Bar Association; (standing, left to right) Hart Page, OSMA Executive Director; Maurice F. Lieber, M.D., OSMA President-Elect; James E. Pohlman, Esq., Columbus; and Joseph B. Miller, Executive Director of Ohio State Bar Association. The group voted to meet again in early March to investigate possible solutions.

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Early and Periodic Screening, Diagnosis and Treatment of Children Under Title XIX (Medicaid)

On October 29, 1974, the OSMA Council passed the following recommendation: OSMA should encourage physicians to become familiar with and to participate in the Early Periodic Screening, Diagnosis and Treatment national program amendments to Title XIX (Medicaid) of the Social Security Act, with the screening being done by the recipient's personal physician.

In order to help physicians become familiar with the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program, following is a compendium of the program.

History

The Medicaid Program has a legislative mandate to screen, diagnose, and treat the health problems of eligible children under 21. The law (PL90-248) was signed January 2, 1968 as an amendment to Medicaid. The amendment was "intended to direct attention to the importance of preventive health services and early detection and treatment of disease in children eligible for medical assistance."

Although this amendment, signed in January 1968, required states to have screening programs in operation by July 1969, little was accomplished. On February 7, 1972, regulations appeared requiring all states to provide EPSDT for children under six years of age and all Medicaid-eligible children, ages 0-21, to be included by July 1973. If a state did not offer EPSDT as part of the Medicaid program, they were technically not in compliance with federal law and could be subject to a lawsuit. Also in 1972, new amendments to the Medicaid Act were passed (PL92-603). In Section 299F of these amendments, Congress underscored its interest in this program by adding a penalty provision. States would lose one percent of the federal funds they receive for ADC welfare programs after July 1, 1974, if the state failed to (1) inform all families in the state under an approved ADC program of the availability of child health screening services under the Medicaid approved plan, (2) provide or arrange for the provision of these screening services in all cases where requested; (3) arrange for, directly or through referral to appropriate agencies, organization, or individuals, corrective treatment, the need for which is disclosed by the child's health screening services.

Purpose

The following is a quote from a Guide to Screening: EPSDT-Medicaid, prepared by the American Academy of Pediatrics. "The purpose of a health screening program is to bring needed medical care to children who are not receiving it. Screening programs accomplish this goal by identifying children with health problems or needs that

have not been recognized or have not been fully cared for, and by ensuring that problems are adequately diagnosed and treated.

If every child is to receive needed care, some person or persons must periodically survey each child to be sure there are no hidden problems, that the medical significance of any symptoms is known, that evidence of neglect and/or child abuse is identified and that necessary preventive and remedial measures are being taken. The Early and Periodic Screening, Diagnosis and Treatment Program is designed to accomplish this task. Screening, Diagnosis and Treatment Programs are not an adequate Substitution for the regular, continuing health supervision and care which every child requires. . . "

Private and group practice physicians already participating under Medicaid can request a handbook on EPSDT and form DPW 2553 (Periodic Screening Invoice) from the Ohio Department of Welfare; Division of General Support Services; 227 N. Front Street, Columbus, Ohio 43215.

Private and group physicians not participating under Medicaid and wishing to participate under the EPSDT program should request a provider application form from Provider Relations Section, Ohio Department of Public Walfare by calling this toll-free number: 1-800-282-0340.

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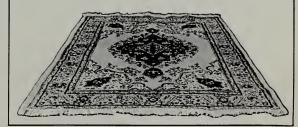
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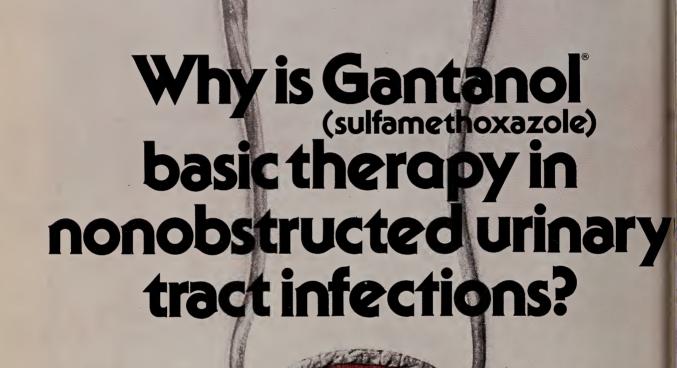
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Contraindications: Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

Warnings: Safety during pregnancy has not been established.
Sulfonamides should not be used for group A beta-hemolytic strep-

tococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

Precautions: Use cautiously in patients with impaired renal of hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: Blood dyscrasias (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, pur

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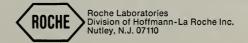
pura, hypoprothrombinemia and methemoglobinemia); allergic reactions (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); gastrointestinal reactions (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); CNS reactions (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); miscellaneous reactions (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis).

Usual adult dosage: 2 Gm (4 tabs or teasp.) initially, then 1 Gm b.i.d. or t.i.d. depending on severity of infection.

Usual child's dosage: 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs b.i.d. Maximum dose should not exceed 75 mg/kg/24 hrs.

Supplied: Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.



Scientific Programs For OSMA's 1975 Annual Meeting

The 1975 Ohio State Medical Association Annual Meeting will provide the platform for many scientific sections and specialty societies to present the latest in continuing medical education programs. This issue does not cover ALL PROGRAMS since several were not complete at press time.

The 1975 Ohio State Medical Association Annual Meeting will present scientific programs starting Monday afternoon, May 12 and running through Wednesday afternoon, May 14. Most programs will be held at the Veterans Memorial Building and the Sheraton-Columbus Hotel. However, to be certain of time and place, refer to your official program at the Annual Meeting.

All exhibits will open at noon Monday, May 12 at the Veterans Memorial Building. Support the exhibitors by stopping by and reviewing their latest products or services; let them know we appreciate

their presence at our meeting.

WATCH the April Journal Issue for a complete schedule on Continuing Medical Education Courses being offered during the meeting. Several courses will be held at the Sheraton-Columbus Hotel and several will be held at the Veterans Memorial Building. Each course will start Tuesday and be continued on Wednesday. Courses will be limited to an enrollment of 35 persons each with a registration fee of \$15.00 per person for the entire course. Look to your state association for your Continuing Medical Education.

MONDAY, MAY 12
GENERAL SESSION
1:30-3:30 P.M.
(Veterans Memorial)
"Current Status of Professional Liability
Problems and Solutions"

This general session will be designed to provide the most current information on the "professional liability" issues, problems, as well as OSMA activities and solutions. Speakers will be selected on a date closer to the time of the meeting to ensure the most up-to-date information available is presented.

SCIENTIFIC PROGRAM 1:30-5:00 P.M. (Veterans Memorial) "Acupuncture and Neuromodulation: Here to Stay?"

This program is sponsored by the scientific section on Physical Medicine and Rehabilitation of the Ohio State Medical Association. Two outstanding speakers will headline this program.

George W. Waylonis, M.D., Columbus, Associate Professor, Department of Physical Medicine, College of Medicine, the Ohio State University and Medical Director, Department of Physical Medicine, Riverside Hospital will direct his presentation on "Acupuncture in Physical Medicine: Another Modality." Dr. Waylonis has been involved in acupuncture research for the last two years in conjunction with the Department of Physical Medicine at Ohio State University.

Charles V. Burton, M.D., Minneapolis, Minnesota will provide the second portion of the program on "Neuromodulation." Dr. Burton is Director of the Department of Neuroaugmentive Surgery at the Sister Kenny Institute. Dr. Burton was educated at the Johns Hopkins University, Baltimore, Maryland and attended the New York Medical College followed by internship at Yale Medical Center (Surgery). In 1966, he was Chief Resident in Neurological Surgery at Johns Hopkins Hospital. Dr. Burton has received a number of fellowships and honors.

TUESDAY, MAY 13 9:00 A.M.

(Sheraton-Columbus Hotel)
"Emergency Medical Service in Ohio:
Making It Better"

This program is sponsored by the Ohio Committee on Trauma, A.C.S. and will feature an outstanding program on Emergency Medical Service in Ohio. Charles F. Frey, M.D., Ann Arbor, Michigan, Director, Region V Committee on Trauma of American College of Surgeons in 1974 to present and Professor of Surgery at the University of Michigan Medical Center will be the out-of-state speaker. The entire program with participants is as follows:

Moderator: Robert C. Waltz, M.D., Cleveland

9:00 a.m. The Community College in EMT Training—Mr. Thomas McCort, Allied Health Sciences, Cuyahoga Community Hospital.

9:20 a.m. Advancing the Role of the R.N. in the Management of the Critically Ill and Injured—(Speaker to be announced)

9:40 a.m. The Emerging EMS Program in Cleveland—Robert C. Waltz, M.D., Cleveland.

10:00 a.m. Question Period

10:10 a.m. Coffee Break

Moderator: Robert M. Zollinger, Jr., M.D., Cleveland

10:40 a.m. The State EMS Program—Current Issues—John Ackerman, M.D., Director, Ohio Department of Health

11:00 a.m. National Program in Trauma—John Howard, M.D., Toledo

11:20 a.m. A Critical Review of Existing EMS Systems—Charles Frey, M.D., Ann Arbor, Michigan

11:40 a.m. Question Period

12:00 Noon Luncheon and Business Session (Shertton-Columbus Hotel)

9:00 A.M. (All Day) (Veterans Memorial)

"A Modern Appraisal of Breast Diseases:
A Seminar on the Role of Radiology, Pathology,
and Surgery"

This program is sponsored by the OSMA Section on Pathology and the Ohio Society of Pathologists. Participants in the program will be: John B. Hamblet, M.D., President, Ohio Society of Pathologists; J. Beach Hazard, M.D., Moderator, Emeritus, Chairman, Department of Pathology, Cleveland Clinic Foundation; George Crile, Jr., M.D., Surgeon, Cleveland Clinic Foundation; Sebastian Cook, M.D., Radiologist, Cleveland Clinic Foundation; William T. Collins, M.D., Pathologist, Lima Memorial Hospital; and Jack C. Geer, M.D., Associate Pathologist, Davidson Laboratories, Columbus. The following schedule with topics will compose the program.

9:00-10:15 a.m. Xeromammography—A Critique Cases 1 and 2

10:15-10:45 a.m. Break to Tour exhibits

10:45-12:00 a.m. The Diagnosis of Lumps in the Breast—Cases 3, 4, and 5

12:00-12:30 p.m. Business Meeting—Ohio Society of Pathologists

2:00- 3:00 p.m. Surgical Treatments of Breast Cancer—Cases 6, 7, and 8

3:00- 3:30 p.m. Break to Tour Exhibits

3:30- 5:00 p.m. Unusual Lesions of the Breast Cases 9, 10, 11 and 12

9:00 A.M. (All Day) (Veterans Memorial) Lung and Chest Problems

Sponsored by the Ohio Chapter of the American College of Chest Physicians, this promises to be an excellent full-day program on the early detection, clinical features and treatment of chronic obstructive lung diseases. An afternoon program follows on emergency management of

chest trauma from the smaller hospital emergency room to the medical center, as well as, acute respiratory failure, diagnosis and treatment from the smaller hospital to the larger medical center. The program is as follows:

9:00-10:20 a.m. "Chronic Obstructive Lung Disease Complex: Emphysema,
Bronchitis, Asthma: Early Detection, Clinical Features and
Treatment"

Moderator: Barney M. Wisinger, M.D., Chief,
Pulmonary Division, Medical
College of Ohio at Toledo;
and President Ohio Chapter,
of American College of Chest
Physicians

Pathophysiology of Chronic Obstructive Lung Disease — Dennis E. Niewoehner, M.D., University Hospital, Cleveland

Allergic Aspects of Chronic Obstructive Lung Disease — Roy L. Donnerberg, M.D., Ohio State University Hospital.

Treatment of Chronic Obstructive Lung Disease—Robert Loudon, M.D., ChB; Professor of Medicine and Director of Pulmonary Disease Division, University of Cincinnati College of Medicine.

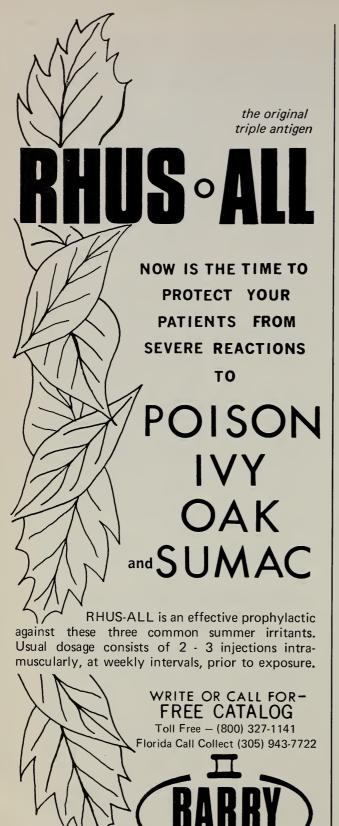
10:20-10:30 a.m. Break

10:30-12:00 noon "Pneumonia Today: Changing Patterns of Etiology and Treatment"

Moderator: Stuart M. Brooks, M.D., Chief, Clinical Studies Division, Department of Environmental Health and Associate Professor of Medicine and Environmental Health, at the University of Cincinnati College of Medicine

Noscomial Gram Negative and Pneumonias — K. V. Gopalkrishna, M.D., Chief, Infectious Diseases, VA Hospital, Cleveland.

Anerobic Pneumonias — Robert Fass, M.D., Assistant Professor of Medicine, Division of Infectious Diseases, Ohio State University Hospital (Continued)



POMPANO BEACH, FLORIDA 33064

(Continued from page 167)

Radiological Aspects of Pneumonias — Atis K. Freimanis, M.D., Professor and Chairman of the Department of Radiology, Medical College of Ohio at Toledo

12:00 Noon-2:00 p.m. Business Meeting and Luncheon

2:00- 3:20 p.m. "Emergency Management of Chest Trauma: From the Smaller Hospital Emergency Room to the Medical Center"

Moderator: **Donald Woodson, M.D.,** Governor, Ohio Chapter of American College of Chest Physicians, Toledo.

> Chest Wall and Soft Tissue Trauma — William H. Falor, M.D., Chief, Division of Thoracic Surgery, Akron City Hospital and Children's Hospital of Akron.

> Cardiovascular Trauma— John J. Turner, M.D., Vice-Chief of Surgery and Chief of Thoracic and Cardiovascular Surgery, Northside Hospital, Youngstown.

> Pulmonary and Esophageal Trauma — Karl P. Klassen, M.D., Professor and Director, Division of Thoracic Surgery, Children's Hospital and University Hospital, Ohio State University College of Medicine.

3:30- 5:00 p.m. "Acute Respiratory Failure, Diagnosis and Treatment: From the Smaller Hospital to the Larger Medical Center"

Moderator: Barney Wisinger, M.D., Toledo

Diagnosis of Respiratory Failure in the Smaller General Hospital—Michael W. Craig, M.D., Dayton.

Diagnosis and Treatment of Acute Respiratory Failure in the Larger Medical Center— Arno Freihofer, M.D., Assistant Professor of Medicine, University of Cincinnati College of Medicine. Respiratory Failure in the Postop Surgical Patient—Charles V. Meckstroth, M.D., Associate Professor of Surgery, Division of Thoracic Surgery, Ohio State University College of Medicine.

1:30 P.M. (Veterans Memorial) Rheumatology

Sponsored by the Ohio State Medical Association Section on Rheumatology and the Ohio Rheumatism Society, the program will deal with the many aspects of Rheumatic Diseases. Gerald Rodnan, M.D., Pittsburgh, Pa. will be the out-of-state guest speaker. Dr. Rodnan is professor of medicine and Chief of the Division of Rheumatology and Clinical Immunology at the University of Pittsburgh. The program is as follows:

- 1:35 p.m. Historical Aspects of Rheumatic Disease—Gerald Rodnan, M.D., Pittsburgh, Pennsylvania
- 2:05 p.m. Clinical Diagnosis and Treatment of Gout—Vol K. Philips, M.D., Ohio State University, Columbus
- 2:35 p.m. Intermission
- 2:45 p.m. Clinical Diagnosis and Treatment of Rheumatoid Arthritis—Joseph Levinson, M.D., University of Cincinnati.
- 3:15 p.m. Clinical Diagnosis and Treatment of Lupus Erythematosus — Arthur L. Scherbel, M.D., Cleveland Clinic Foundation.

3:45 p.m. Discussion

9:00 A.M. (All Day) (Veterans Memorial) Ear, Nose and Throat

Two out-of-state speakers will participate in the program sponsored by the Ohio Ear, Nose and Throat Society and the OSMA Section on Ear, Nose and Throat. Listed below is the all day program which will be of great interest to all otolaryngologists as well as many other specialties.

Presiding: John H. Boyles, Jr., M.D., Dayton, President, E. N. T. Section.

9:00 a.m. Tympanoplasty: Undersurface vs.
Overlay Technique and Ossicular
Reconstruction—Michael E. Glasscock, III, M.D., Clinic Professor of
Surgery, Vanderbilt University.

(Continued on next page)

The Pain Phone

When a telephone prescription for pain relief is necessary or convenient, you can call in your order for Empirin Compound with Codeine in 45 of the 50 states! That includes No. 4, which provides a full grain of codeine for more intense, acute pain.



(Continued from page 169)

9:45 p.m. Notched Incus in Tympanoplasty— Roger E. Wehrs, M.D., Associate Professor of Otology, University of Oklahoma.

10:30 a.m. Discussion

10:45 a.m. Break

11:00 a.m. Modern Development in Amplification: Theorectical and Practical Applications—Joseph P. Millin, Ph.D., Professor in Audiology Speech & Hearing Clinic, Kent State University.

11:45 a.m. Melvin Emanuel, Ph.D., Director of Speech and Audiology at Childrens Medical Center, The Ideal Hearing Aid Dispensing Agency.

12:30 p.m. Lunch China-Malay—(Sheraton-Columbus)

2:00 p.m. Obliteration of the Mastoid Cavity and Contraindications to Tympanoplasty — Michael E. Glasscock, III, M.D.

2:45 p.m. Reconstructive Mastoidectomy with Homograft Knee Cartilage—Roger E. Wehrs, M.D.

3:30 p.m. Discussion

3:45 p.m. Break

4:00 p.m. Video tape presentation on Functional Radical Neck Dissection made by Ettore Bocca, M.D., Milan, Italy. Presentation followed by comments by Daniel M. Lavigna, Jr., M.D., Assistant Professor of Otolaryngology, Ohio State University.

OPHTHALMOLOGY

The Ohio Ophthalmological Society will meet in conjunction with Ohio State Medical Association Annual Meeting on Tuesday, May 13. The following schedule will precede the scientific program sponsored by the Ohio Ophthalmological Society and OSMA Section on Ophthalmology.

8:00 a.m. Board of Governors Meeting, Ohio Ophthalmological Society, Scioto Country Club, 2196 Riverside Drive, Columbus.

10:00 a.m. Annual Business Meeting, Ohio Ophthalmological Society, Scioto Country Club.

12:00 Noon Luncheon, Scioto County Club.

Scientific Program (Veterans Memorial Building)

2:30 p.m. Photocoagulation in Presumed Histoplasmic Maculopathy—Lawrence A. Raymond, M.D., Dept. of Ophthalmology, University of Cincinnati Medical Center.

2:45 p.m. The Single Horizontal Muscle Operation, A Survey—Rees W. Sheppard, M.D., Dept of Ophthalmology, University of Cincinnati Medical Center.

3:00 p.m. Cataract Surgery, Plain and Fancy— L. L. Hyde, M.D., Assistant Professor Ophthalmology, University of Kansas.

3:45 Break

4:05 p.m. The Use of Fresnel Prisms in Under and Over Corrected Exotropia—Gary L. Rogers, M.D., Clinical Instructor, Ohio State University, Department of Ophthalmology.

4:35 p.m. Business Meeting

WEDNESDAY, MAY 14 9:00 A.M. (Veterans Memorial) "Medicine Salutes the Olympics"

Physicians as well as coaches and athletic trainers will find this track-oriented sports medicine program to be stimulating and informative. It will be well-balanced with presentations from an Olypmic team physician, a well-known head track coach, and two recent Olympic gold medal winners. This program is sponsored by the OSMA Sections on Sports Medicine and General Practice.

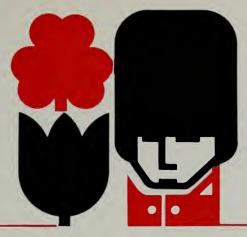
9:00 a.m. Welcome—Sol Maggied, M.D., Chairman, OSMA Section on Sports Medicine.

9:05 a.m. Remarks — Benjamin Berger, M.D., Cleveland (Father of Olympic Coach David Berger, killed in Vienna, 1972) Introduced by Thomas Hughes, M.D.

9:20 a.m. Medical Observations of Olympic Athletes—Donald Cooper, M.D., Director, Oklahoma State University Health Center and Team Physician, Oklahoma State University, Stillwater, Oklahoma.

10:00 a.m. Break for Tour of Exhibits

10:30 a.m. Coaching the Olympic Runner—Mel
Brodt, Head Track Coach, Bowling
Green State University.



OHIO STATE MEDICAL ASSOCIATION



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DEPARTING CLEVELAND AND COLUMBUS - JUNE 28

City ______State Medical Association Send to: State Medical Association Send to: Send to: State Medical Association Send to: Send



(Continued from page 170)

- 11:00 a.m. Running for the Gold David J.

 Wottle, Wadsworth, 7 time AllAmerican in track and cross country;
 NCAA Top 5 scholar-athlete; presently running with the international track association.
- 11:20 a.m. Olympics—Past and Future— Madeline Manning Jackson, Cleveland, Winner in 1968 and 1972 gold and silver medalist in the Olympics, World and American record holder in Women's track and field.
- 11:40 a.m. Drugs in the Olympics—Robert Murphy, M.D., Columbus, Head team physician, Ohio State University.

9:00 A.M. (All Day) (Veterans Memorial) PLASTIC SURGERY

The Section on Plastic Surgery will devote the entire morning program to the presentation of its guest speaker followed by a panel discussion. Guest Speaker: Ray A. Elliott, Jr., M.D., Albany, New York; Associate Clinical professor of plastic surgery (Albany Medical College); Member of Board of Directors of the Educational Foundation of ASPRS and author of numerous scientific papers. Dr. Elliott will discuss "Head and Neck Cancer—Reconstructive Techniques", the repair of defects created by the excision of malignant tumors of the head and neck.

Panel Participants:

Clifford Kiehn, M.D., Cleveland; John DesPrez, M.D., Cleveland; John Brogan, M.D., Cincinnati; and George Baibak, M.D., Toledo.

11:30 a.m. (Lunch followed by business meeting)

Scientific Program

- 1:00 p.m. Unusual Abnormalities of the Ears and Shell Ears—Bahram Kadivar, M.D., Cincinnati.
- 1:20 p.m. Our Current Management of Flexor Tendon Injuries — James Sullivan, M.D., Toledo.
- 1:40 p.m. Experiences with the Intravelarveloplasty in the Cleft Palate Child— Ronald Berggren, M.D., Columbus.
- 2:10 p.m. Full Thickness Skin Grafts in the Reconstruction of the Burn Patient— Elmer Raus, M.D., Parma
- 2:30 p.m. Complications of Breast Reconstruction—H. William Porterfield, M.D.; Lester Mohler, M.D. and James Ferraro, M.D.

1:30 P.M. (Veterans Memorial) ALLERGY

The OSMA Section on Allergy and the Ohio Society of Allergy and Immunology will present the following scientific program.

- Presiding: James I. Tennenbaum, M.D., Columbus, Chairman, OSMA Section on Allergy.
- 1:30 p.m. Non Allergic Causes of Wheezing in Children Joseph M. Mattimore, M.D., Clinical Assistant, Professor of Pediatrics, State University N.Y. at Buffalo.
- 2:00 p.m. Rehabilitation of Asthamatic Children
 —Joseph E. Ghory, M.D., Clinical
 Professor of Pediatrics, University of
 Cincinnati College of 'Aedicine and
 Medical Director, Cor.valescent Hospital for Children.
- 2:30 p.m. The Antonomic Nervous System and Asthma—D. Duane Hauser, M.D., Director of Immunology, Education Service, Methodist Hospital, Indianapolis, Indiana.
- 3:00 p.m. Question and Answer Period—Doctors

 Mattimore, Ghory and Hauser.
- 3:30 p.m. Business meeting of the Ohio Society of Allergy and Immunology.

1:30 P.M. (Veterans Memorial) "Venereal Disease Update—1975"

The newly organized OSMA Scientific Section on Dermatology will hold its first scientific meeting in connection with the OSMA Annual Meeting.

- Moderator: Robert Brownlee, M.D., Program Chairman, Section on Dermatology, Columbus.
 - 1:30 p.m. Modern Venereal Diseases F. D. Lowney, M.D., Chief, Division of Dermatology, Ohio State University.
- 2:30 p.m. Question and Answer Period
- 2:45 p.m. Syphilis: The 1975 Anachronism—Don W. Printz, M.D., Tucker, Georgia (native of Lima, Ohio), who was assigned to the venereal disease control project in Columbus which has served as the National model for the Gonorrhea control program.
- 3:45 p.m. Question and Answer period.

Provisions in OSMA Bylaws Pertaining to Nomination of President-Elect

Attention is called to provisions in the Bylaws of the Ohio State Medical Association pertaining to the nomination and election of the President-Elect at the OSMA Annual Meeting. The President-Elect and other officers are elected by the House of Delegates, meetings of which will be held during the Annual Meeting in Columbus, May 11-14.

Nominations of the President-Elect are to be made 60 days in advance of the meeting at which election takes place and information on nominations published in The Journal, unless these provisions are waived by a two-thirds vote of the House of Delegates. The 60-day deadline is March

The part of the OSMA Bylaws pertaining to this procedure is Chapter 5, Section 3, entitled "Nomination of President-Elect."

"Nominations for the office of President-Elect shall be made from the floor of the House of Delegates; provided, however, that only those candidates may be nominated whose names have been filed with the Executive Director at the time

and in the manner hereinafter provided, unless compliance with such requirements shall be waived as hereinafter provided. The name of a candidate for the office of President-Elect must be filed with the Executive Director of the Association at least sixty (60) days prior to the meeting of the House of Delegates at which the election is to take place. Promptly upon the filing of such candidate's name, the Executive Director shall prepare and transmit this information to each member of the House of Delegates. No nomination for President-Elect may be presented at any meeting of the House unless the foregoing requirements of filing and transmittal have been complied with or unless such compliance shall have been waived or dispensed with by a vote of at least two-thirds (2/3) of the delegates present at the opening session of such meeting. The Executive Director shall cause to be published in The Journal in advance of such meeting of the House of Delegates biographical information on all candidates meeting the requirements of filing and transmittal."

One out of every 50 drivers you meet on the highway is drunk. The Ohio Department of Highway Safety urges you to do something about it. Contact your legislators and judges. Let them know you want tough laws against drunk drivers and that you want them strictly enforced.



DESCRIPTION: Methyltestosterone is 178-Hydroxy-17-Methylandrost-4-en-3-one. ACTIONS: Methyltestosterone is an oil soluble androgenic hormone. INDICATIONS: In the male: 1. Eunucholdism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with laundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. PRECAUTIONS: Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. CONTRAINDICATIONS: Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. MRNINGS: if priapism or other signs of excessive sex. Walknings: if priapism or other signs of excessive sex. Walknings: In priapism or other signs of excessive and sex and simulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or preoccious sexual development. Hypersensitivity and gynecomasta may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. ADVERSE REACTIONS: Cholestatic jaundice • Oligospermia and

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Bioequivalence

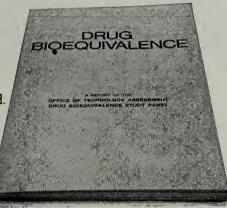
the weight of scientific opinion:

If the pharmacist substituted a chemically equivalent drug for the one you have specified for your patient—could you be certain of that product's safety and effectiveness simply because the chemical content was the same?

Definitely not, unless bioequivalence tests and other quality assurance checks had been conducted. The pharmaceutical industry and many scientists have maintained this position for years, but others have questioned it. Now the Office of Technology Assessment of the Congress of the United States has reported on the issue in its Drug Bioequivalence Study.*

Here are a few definitive statements in the O.T.A. report:

"... the problem of bioinequivalency in chemically equivalent products is a real one. Since the studies in which lack of bioequivalence was demonstrated involved marketed products that met current compendial standards, these documented instances constitute unequivocal evidence that neither the present standards for testing the finished product nor the specifications for materials, manufacturing process, and controls are adequate to ensure that ostensibly equivalent drug products are, in fact, equivalent in bioavailability.



"While these therapeutic failures resulting from problems of bioavailability were recognized and well documented, it is entirely possible that other therapeutic failures and/or instances of toxicity that had a similar basis have escaped attention."

The Pharmaceutical Manufacturers Association supports federal legislative amendments that would require manufacturers of duplicate prescription pharmaceutical products, subject to new drug procedures, to document:

(a) chemical equivalence; and

(b) biological equivalence, where bioavailability test methods have been validated as a reliable means of assuring clinical equivalence; or (c) where such validation is not possible, therapeutic equivalence.

In addition, the PMA supports federal legislation that would require certification of all manufacturers of prescription products before they could start in business, annual inspections and certification thereafter, and strict adherence to FDA regulations on good manufacturing practices.

The overall quality of the United States drug supply is excellent. But only a total quality assurance program, envisaged in these and other policy positions adopted by the PMA Board of Directors in 1974, can bring about acceptable levels of performance by all prescription drug manufacturers and thereby assure the integrity of your prescription...



Pharmaceutical Manufacturers Association 1155 Fifteenth Street, N.W. Washington, D.C. 20005

*Copies of the complete report on Drug Bioequivalence may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

protecting the integrity of your prescription

Deadline for Submission of Resolutions to OSMA Office is March 12

Delegates to the Ohio State Medical Association and County Medical Societies planning to have resolutions submitted for consideration by the House of Delegates at the 1975 Annual Meeting should be guided by Chapter 4, Section 8 of the OSMA Bylaws entitled "Resolutions."

"Every resolution to be presented to the House of Delegates for action shall be filed with the Executive Director of the Association at least (60) days prior to the first day of the meeting at which action on such resolution is proposed to be taken; and promptly upon the filing of any such resolution the Executive Director shall prepare and transmit a copy thereof to each member of the House of Delegates. No resolution may be presented or introduced at any meeting of the House of Delegates unless the foregoing requirements for filing and transmittal shall have been complied with or unless such compliance shall have been waived by a Special Committee on Emergency Resolutions named to decide whether late submission was justified. This special committee shall consist of the chairmen of the several resolution committees. If a majority of the members of the Special Committee on Emergency Resolutions vote favorably for waiving the filing and transmittal requirement, then such resolution shall be presented to the House of Delegates at its opening session. All resolutions presented subsequent to the 60-day filing date prior to the opening session of the House of Delegates shall be submitted by their sponsors to the committee no less than 12 hours prior to the opening session of the House of Delegates."

OSMA Group Ordinary Life Insurance Pays Dividend

A 25½ percent cash dividend was paid recently to all participants in the Ohio State Medical Association Group Ordinary Life Insurance Plan.

Turner and Shepard, Inc., the plan's administrator, announced the dividend to their insured in December, 1974. This plan has a history of outstanding dividends. In 1972, the plan paid 14 percent, and in 1973, paid 26 percent. This averages 21.8 percent over the last three years.

Cash dividends are to be considered as premium returns, and therefore need not be reported as income.

Physicians with a need for greater life insurance protection have found this Association-sponsored plan to be a valuable addition to their portfolio.

In addition to the consistent yearly dividends, the plan includes accidental death and dismemberment insurance and a waiver of premium in case of disability.

If you have any questions about the Ohio State Medical Association's Group Ordinary Life Plan, low cost Group Term Life Plan, or Group Disability Income Plan, please contact Turner and Shepard, Inc., 17 South High Street, Columbus, 43215, (614) 228-6115.

Sports Medicine Conference Draws 300 Participants

Nearly 300 physicians, coaches, athletic trainers, student trainers and physical education instructors participated in the Southwestern Ohio Sports Medicine Conference on Saturday, January 25 at Fairborn-Baker High School, Fairborn. The Conference was co-sponsored by the Ohio State Medical Association and the Ohio High School Athletic Association.

Highlighting the program were demonstrations of taping and bandaging techniques as well as presentations on the role of the female athlete, prevention and treatment of head and neck injuries, knee injuries, shoulder injuries and dental injuries, role of the team physician, and strengthening and conditioning exercises for better athletic performance.

David H. Shon, head athletic trainer at Wright State University near Fairborn, served as program coordinator for the conference. Serving as host and site coordinator was Lloyd Williams, athletic director at Fairborn-Baker High School.

The State Board of Education has urged scholastic coaches and others involved with sports programs to participate in the OSMA-OHSAA conferences following adoption of its resolution which states:

"The faculty member (coach) responsible for students participating in interscholastic athletics such as football, basketball, track and field, baseball and wrestling, should evidence knowledge about the medical aspects of sports activities, and should continuously be apprised of the latest developments emanating from the medical and training research on sports activities."

Since September, 1974, sports medicine conferences have also been conducted in Lima, Nelsonville, Columbus, Euclid, Berea, and Cleveland.



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If by some chance you haven't gotten acquainted with your Blue Shield professional relations man yet, give him a call today. You'll find he's a handy guy to have around.



OHIO MEDICAL INDEMNITY, INC.

AMA Annual Meeting

June 15-19, 1975

Atlantic City, New Jersey

Resolutions

The deadline for introducing Resolutions before the AMA House of Delegates is May 15, 1975. Resolutions proposed by the Ohio State Medical Association House of Delegates may be introduced within 10 days of the conclusion of OSMA's Annual Meeting (May 11-14). Emergency Resolutions to be considered by the AMA House of Delegates require review by a committee appointed by the Speaker of the House, and then a favorable vote by a two-thirds majority of the House. (During the AMA's December 1974 Clinical Convention, no emergency Resolution received favorable action and therefore, none was considered by the House.)

Individual members of OSMA, state or local specialty medical societies, or groups wishing to have a member of the Ohio delegation present a *Resolution* before the AMA House of Delegates should contact: Dr. John Robechek, Co-chairman of the AMA Delegation, 3461 Warrensville Center Rd., Cleveland, 44122; or Jerry Campbell, OSMA Headquarters, 600 S. High St., Columbus 43215. Contact must be made before May 10.

Handbooks

The Handbook for AMA Delegates to the Annual Meeting will contain the reports of the AMA Board of Trustees, Councils, Committees, and Resolutions proposed prior to May 15. The Handbook should be available by June 1. The delegates will have 10-12 days to study this material and seek reference or background so they may better understand proposed legislative programs.

AMA Delegates

On recommendation to the AMA delegates, the OSMA Council approved the following:

- 1) All AMA delegates and alternate delegates from Ohio must be members in good standing with both the OSMA and AMA.
- 2) AMA delegates are asked to support retention in the AMA Constitution that one of the objectives of the AMA is "to promote the health of the people." Likewise, AMA delegates are asked to support the concept that physicians should involve themselves in working toward enriching the medical aspects of the quality of life. The OSMA will request the privilege of appearing before the AMA Council on Constitution and Bylaws during hearings on this subject.
- 3) AMA delegates are requested to continue support of OSMA's position that ultimate authority is vested in the AMA House of Delegates over all councils, including the Judicial Council of the AMA (Resolution #22, Clinical Meeting 1974). OSMA will request the privilege of presenting its position during hearings on this subject to be held by the AMA Council on Constitution and Bylaws.

The AMA delegates and OSMA Council members were informed on January 31 by Dr. John Budd, Cleveland, who is a memmber of the AMA Board of Trustees, that the \$60.00 AMA assessment for 1975 in the opinion of the Board of Trustees is a "compulsory" assessment. At a meeting to be held prior to the AMA Annual Meeting, the proposed increase in AMA annual dues will be discussed. This is one of the principle items deferred at the Clinical AMA Meeting in Portland which will be acted upon at the meeting in Atlantic City.

HOW TO LAUGH



AT POLITICS

MARK RUSSELL

If you have not heard Mark Russell you are in for a treat and if you have heard him you will be certain to return and hear him again. His song parodies and satire made him popular with the Congressional crowd, and in 1961, he moved to his present entertainment spot at the Shoreham. He is so tuned to events and personalities in Washington, that the local politicos sometimes mistake him for one of their peers. If life has become a little too serious—let your hair down and laugh along with Mark. Cash bar ... lunch . . . and Mark Russell.

Annual Meeting Pre-Registration and Ticket Form SOCIAL FUNCTION TICKET RESERVATIONS

Note: (No Tickets reserved without money)

Tuesday, May 13, 11:30 A.M.
"OMPAC Luncheon"
Sheraton-Columbus Hotel
\$8.00 per person

Tuesday, May 13
Country Dinner Playhouse

\$12.50 per person (Special Price to all Exhibitors of \$10.00 per person)

Number_ Number___ Name (Please Print) Address. (Number and Street) (City) (State) I am: ☐ OSMA Member ☐ Medical Student Other_ (Fill in) ☐ Guest □ Non-Member Physician Please prepare guest badge for my spouse.

(Please print name)

and a GOOD NIGHT'S LAUGH

with



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OSMA's Night at the Country Dinner Playhouse will be an evening to remember in the rustic setting of the Playhouse. Don't worry about driving . . . buses will be available . . . first bus will leave the Sheraton-Columbus Hotel, 50 North Third Street, starting at 6:00 p.m. and will return you to the hotel following the show. In addition to the show . . . there will be an open bar, and a lavish buffet dinner served. Purchase your tickets NOW . . . don't delay. ADVANCE REGISTRATION FORM ON REVERSE SIDE.

TUESDAY
MAY 13
LAUGH IN'S
MARK RUSSELL
AND
VAN JOHNSON



Applications Open for 1975 National Humanities Seminars

A series of five seminars for physicians and other health professionals during the summer and fall of 1975 will be funded by the National Endowment for the Humanities. Participants will explore ethical conflicts, the rights of patients, the purpose and limits of medical professions and their relations to the community.

The National Endowment for the Humanities is a U.S. Government agency, established in 1965, as part of the National Foundation on the Arts and Humanities. The seminar program, an expansion of the series inaugurated in 1974, will bring together for a month of full-time study and discussion medical practitioners and distinguished humanists whose work has focused on problems related to medicine and health care. Grants totalling up to \$186,000 will support the seminars.

Twelve to fifteen participants will be chosen for each seminar. They will attend tuition-free and receive stipends of \$1,200 plus a travel allowance of up to \$300. The seminars are scheduled for month-long periods with three beginning in June,

one each in July and September.

One seminar will take place on the Ohio State University campus, directed by John C. Burnham, Professor of History and Lecturer in Psychiatry. Scheduled from June 23 to July 18, this seminar will aim at identifying the particular historical forces which have shaped the medical profession and determined the direction of its development.

The remaining four seminars will be at the: University of Texas Medical Branch at Galveston, directed by H. Tristram Engelhardt, Jr.; University of Pennsylvania, directed by Renee C. Fox; and Williams College (Williamstown, Mass.), one directed by William F. May of Indiana University and another directed by Leon R. Kass of the Kennedy Institute of Georgetown University.

Anyone desiring more detailed information and application forms can contact the individual

seminar directors.

Physicians To Exhibit Art At AMA Annual Convention

Once again the American Physicians Art Association will sponsor the popular exhibition of Physicians Art at the AMA Annual Convention, June 14-18, in the Atlantic City Auditorium and Convention Hall.

Victor C. Laughlin, M.D., Cleveland, who is president of the APAA, said the display will include paintings, sculpture, photography and crafts by members of the medical profession. Any physician interested in any phase of art is invited to display

his talent. Prizes will be awarded in numerous categories.

Anyone interested in exhibiting or becoming a member of the APAA should contact Dr. Laughlin at 3270 Green Road, Cleveland 44122.

AMA Directory Lists 4,000 Blood Banking Facilities

Information on blood banking and transfusion activities at more than 4,000 facilities in the United States is included in the latest edition of the "Directory of Blood Banking and Transfusion Facilities and Services," a publication of the American Medical Association.

The current edition of the book is the third such Directory to be compiled by the AMA. The data was gathered through mailing of a questionnaire to all blood facilities known to the AMA and other organizations interested in blood. The survey counted 7,271,967 units of blood collected in the U.S. and its possessions in 1971. The survey, the first to be completely handled by computer, was conducted by the Committee on Transfusion and Transplantation.

Copies of the book are available from the Order Department, American Medical Association, 535 N. Dearborn St., Chicago, Ill. 60610. Cost for 1 to 10 copies is \$3; 11 to 49 copies is \$2.70 each,

and 50 or more copies is \$2.40 each.

Adopts Acupuncture Policy

The AMA, in considering the status of acupuncture at its recent convention in Portland adopted a policy that would limit the practice of acupuncture to a research setting.

Acupuncture, spokesmen said, is an unproved therapeutic procedure. Concern was voiced in the House of Delegates over the number of acupuncture clinics opening up and run by nonphysicians.

Part of the AMA's position statement says the procedure should be performed in a research setting by a licensed physician or under his direct supervision and responsibility.

It also recommends that its constituent state and territorial associations seek appropriate legislation and rules and regulations to confine the performance of acupuncture to such research settings.

Model Confidentiality Bill

The AMA's Council on Legislation is speeding up plans to develop model state legislation to preserve confidentiality in the physician-patient relationship.

The model bill, which will be circulated to states and specialty medical societies, will ask for prompt review and comments so that solid guidelines for such legislation can be submitted at the AMA Annual Convention in June.

Two newly-appointed state directors spoke to OSMA Council members and staff during the Council Meeting February 1-2 at OSMA Headquarters. Dr. John Ackerman, (right) Director of Ohio Department of Health, expressed strong belief in the traditional responsibilities of the Ohio Department of Health in the fields of public health and preventive medicine. He stated to the Council "my feeling is that we can do it together." Dr. Timothy Moritz, Director Designate of the Ohio Department of Mental Health and Mental Retardation, was also a special guest. He told the Council the task before him includes action to improve the amount and quality of the professional staff in his department. Dr. Moritz defined his long-range goal as "the build-up of community based systems of care."



Lions Club To Present Research Projects

The Ohio Lions Eye Research Foundation wishes to invite interested ophthalmologists, biophysicists, and medical students to a presentation of research projects on Sunday, April 6 at the Fawcett Center for Tomorrow, 2400 Olentangy Rd., Columbus. Each state medical school, the Departments of Ophthalmology, and Ohio State



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ARNOLD H. KAMBLY, M.D. Psychiatrist-Director

University's Institute for Research in Vision and College of Optometry will present ongoing and future proposals for visual research. The projects are supported by grants from the many Lions Clubs throughout Ohio. A late lunch will be served at 3 p.m. For further information, contact: Dr. Jack M. Fugate, 135 E. Livingston Ave., Columbus, 43217; or Dr. Lester Stein, 226 N. Fourth St., Steubenville 43952.

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This major addition to the Ohio State University Hospital is planned to provide facilities for supporting and auxiliary hospital services. The architect's sketch shows the south side of the proposed Clinical Medical Sciences Education Facility, for which the university's trustees approved plans last month. Site of the \$12.7-million project would be south of the present hospital. At left in the sketch is Means Hall and at right, a corner of the Health Sciences Library.

OSU Trustees OK Plans For New Hospital Facility

Construction plans for a major supporting service facility for University Hospital have been approved by the Ohio State University Board of Trustees.

The hospital project, known as the *Clinical Medical Sciences Education Facility*, will provide supporting and auxiliary service facilities for University Hospital, as well as a clinical classroom area and a new hospital entrance.

The three-level building will be located south of and parallel to the present University Hospital.

Estimated cost for construction and other expenses was set at \$12.7 million, of which a federal grant will provide \$2.7 million, a state appropriation some \$9.75 million, and hospital reserves the remainder.

Ground floor of the facility will have a new emergency department, new pharmacy, an instrument decontamination and sterilization department, and a central materials handling department. On the first floor will be the new hospital entrance, public lobby and waiting areas; two large clinical classrooms, and a new dietary area for food preparation, storage, distribution and dining room service.

Facilities on the second floor will be the de-

partments of radiology and clinical pathology, a toxicology laboratory and blood bank.

Projected completion date is July, 1978.

Dr. Senhauser To Head OSU Dept. of Pathology

Ohio State University's Board of Trustees have approved the appointment of Dr. Donald A. Senhauser as professor and chairman of the department of pathology. The appointment will become effective next July 1.

A widely known medical educator, Dr. Senhauser is currently professor of pathology in the University of Missouri School of Medicine, Columbia, Mo. He has served also as vice-chairman and acting chairman of pathology and assistant dean of the School of Medicine there.

A native of Tuscarawas County, Ohio, Dr. Senhauser received his bachelor's degree from Columbia University and his medical degree from the College of Physicians and Surgeons, also at Columbia. He was certified by the American Board of Pathology in 1960.

He is a diplomate of the National Board of Medical Examiners and an honor graduate of the U.S. Naval School of Aviation Medicine. He has been on the editorial board of the American Journal of Clinical Pathology since 1965 and is topic coordinator for Continuing Education for the Family Physician, a new journal. He was appointed to the National Committee for Careers in the Medical Laboratory in 1973.

Dr. Senhauser in 1967 was senior staff participant for the American Medical Association Vietnam Medical Education Project at the University of Saigon Medical School. In 1972 he served as consultant for the Study Group on Medical Education in Developing Nations, World Health Organization, Geneva, Switzerland.

He holds membership in the College of American Pathologists, International Academy of Pathology, American Society for Experimental Pathology, and a number of other professional or scientific organizations.

Dr. Senhauser succeeds Dr. Colin R. Macpherson, acting director of Ohio State's department of pathology since July, 1972.

Univ. of Cin. Appoints Dean For College of Medicine

Robert S. Daniels, M.D. Interim Dean of the University of Cincinnati College of Medicine, was appointed Dean of the College by the UC Board of Directors.

Dr. Daniels, 47, has served as Interim Dean since early 1973, being at the same time Professor and Director of the Department of Psychiatry in the College of Medicine. His appointment successfully concludes a year-long search. More than 150 possible candidates were reviewed by individuals and committees within the University and its Medical Center. Following these thorough studies Dr. Daniels emerged as the unanimous choice of the search groups.

Both his baccalaureate and medical degrees were earned at the University of Cincinnati. Dr. Daniels was elected to Phi Beta Kappa, Alpha Omega Alpha, the honorary medical society, and received the Hoffheimer scholarship award for ranking first in academic standing upon graduation from medical school. He served his internship at the Cincinnati General Hospital, where he also took his psychiatric residency training.

From 1957 to his return to Cincinnati in 1971, Dr. Daniels served as a faculty member in the Department of Psychiatry at the University of

Chicago's School of Medicine.

He has held appointments as Visiting Professor of Social Medicine and Clinical Epidemiology at St. Thomas's Hospital Medical School in London, England; and Visiting Scientist to the All Soviet Research Unit of Public Health and Epidemiology in Moscow, and Exchange Member of the U.S.-U.S.S.R. Health Exchange Program in the Ministry of Health, Moscow.

Dr. Daniels is a Fellow of the American College of Psychiatrists and the current President of the Cincinnati Psychoanalytic Society. At present he is also chairman of the Psychiatry Training Committee of the National Institute for Mental Health, a branch of the Department of Health, Education and Welfare.

During his two years as Interim Dean, Dr. Daniels led the College of Medicine in planning the move into the new Medical Sciences Building adjoining the Cincinnati General Hospital.

Univ. of Cin. Names New Medical Center Executive

Dr. Lonnie M. Wright of Los Angeles has been appointed Assistant Vice President of the University of Cincinnati and Assistant Director of the Medical Center. His appointment, effective December 30, 1974, involves him in Medical Center planning, coordination, and implementation of new programs.

A wide range of health fields has been included in Dr. Wright's education. He received degrees of Bachelor of Science in Nursing from the University of Oklahoma College of Nursing; Master of Arts in Health Sciences from California State University, San Jose; Master of Public Health in Hospital Administration from University of California, Los Angeles, and Doctor of Philosophy in Health Services Administration from University of Oklahoma College of Health.

Dr. Wright has been Assistant Administrator of the Kaiser Foundation Medical Center and of the Permanente Medical Group of Southern California, as well as Staff Assistant to the Vice President and Regional Hospital Administration of Kaiser Foundation Hospitals.

A news item in the Summit County Labor News of Akron, Ohio on January 10, 1975 tells us that "The Physicians National Housestaff Association (the PHNA-an organization of residents and interns) has joined the Coalition of American Public Employees and entered into a working relationship with the American Federation of State, County and Municipal Employees, AFL-CIO."

Directors of medical education in teaching hospitals, chiefs of clinical divisions responsible for certified and accredited residencies programs, and medical faculties responsible for the postgraduate curriculum should be cognizant of the manner in which this group of physicians (PHNA), under the facade of "graduate medical education," is attempting to replace the world-renowned American medical specialty educational programs with a program relating to collective bargaining and unionism designed for personal gain . . . as differentiated from patient care and the advancement of medical research and education.



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Allergists Establish Joint Council of Socio-Economics

A Joint Council of Socio-Economics of Allergy (ICSEA) has been established to study the efficiency of dollars spent for the care of allergic patients, the quality of care given, and socioeconomic issues relating to the practice of Allergy. The Council is sponsored by the American Academy of Allergy, American College of Allergists, and the American Association for Clinical Immunology and Allergy.

The Council is currently undertaking an extensive survey of all Allergists in the United States to determine the deficiencies in Medicare reimbursement to both the Allergist and his Medicare patient. The survey should uncover areas in which preventive care can be instituted to alleviate the cost burden to the patient and third party payer, as well as the necessity for long term medical care of the patient.

The Council will create and maintain liaisons with the Department of Health, Education and

Welfare, Federal Drug Administration (and other federal, state, and local governmental agencies), Blue Cross, Blue Shield; commercial carriers and associations; American Medical Association and component medical societies and foundations for medical care: Joint Commission on Accreditation of Hospitals; and other individuals and organizations impacting the cost, quality and necessity of medical care.

Health Application Systems, a national firm noted for its expertise in the health care field, has been employed to provide the professional, managerial, financial and technical assistance staff for the Council.

The Student American Medical Association commemorated its 25th anniversary during its annual business meeting held this month in Chicago. In addition, SAMA's House of Delegates convened to vote on proposed legislation and elect new officers. A president-elect was chosen for the first time due to the adoption of a resolution creating the position at last year's SAMA meeting in Dallas.

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PHYSICIAN AND HOSPITAL EQUIPMENT



Following are names of new members of the Ohio State Medical Association certified to the headquarters office during January 1975. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

ALLEN (Lima) Soung-Yoon Huh

COLUMBIA (East Liverpool) Robert Walker Beatty

CUYAHOGA (Cleveland except where noted)
Consuelo G. Cayabyab
Kevin T. Geraci
Parimal K. Ghatak
P. V. Maroo,
Chagrin Falls
Richard C. Pembrook
Cleo A. Rasch
Edmond S. Ricanati

DELAWARE (Delaware) Richard C. Orahood

FAIRFIELD (Lancaster) Henry H. Hood, Jr.

GALLIA (Gallipolis) Murray S. Willock

GEAUGA (Burton) Philip R. Rothrock

GREENE (Xenia) J. S. Waikhom

HARDIN (Kenton)
Chung Ai Chang
Chul Yoo Hong
Leonard K. Smith

HARRISON (Steubenville) Eruch N. Karanjawala

LAWRENCE (Ironton) Ludivina R. Dorado John Alan Mayer

LUCAS (Toledo)
Lawrence A. Birndorf
John H. Robinson
Lance A. Talmage
Richard I. Tapper

MONTGOMERY (Dayton) Eduardo C. Casalmir

PORTAGE (Ravenna) S. S. Solu

RICHLAND (Mansfield) Carlos E. Macfarlane David S. Schwartz

TUSCARAWAS
Rachappa G. Nalawadi
Gnadenhutten
Philip M. Olmstead
Dover
Sanjay N. Shah
Dover

WASHINGTON (Marietta) Se Hwan Whang

WOOD (Bowling Green) Rogelio B. Rufo

Cosmetic Surgeons Establish Peer Review Program

The American Association of Cosmetic Surgeons has announced a peer-review program to assure special competence and standards of physicians practicing aesthetic or cosmetic surgery. The program was established because, no specialty

board certification recognizes and attests to special proficiency in cosmetic surgery.

To qualify for membership in the American Association of Cosmetic Surgeons, a physician must perform 100 or more cosmetic surgery operations each year. He must then apply for a site visit by two members of the Association who witness and evaluate his technical ability and judgment. They also examine results on patients who have undergone surgery by the physician during the previous 12 months.

At the end of each calendar year, members will be required to submit a list of the procedures they performed during that period. Once a candidate has been accepted, membership recertification will depend on re-evaluation of capability every three years. Membership in the Association will therefore indicate that those who are best able to evaluate a surgeon's competence have approved his capability and current performance.

The Association emphasized that it is not trying to usurp or transcend the function of any certifying Board. It is simply providing what it believes to be the best mechanism devised of assuring the American public of quality control and continuing proficiency in cosmetic surgery.

Call For Abstracts

A "Call for Abstracts" has been announced by the American College of Chest Physicians. The program committee for the 41st Annual Scientific Assembly invites submission of abstracts in the disciplines of circulation, respiration, thoracic/cardiovascular surgery and related systems. Accepted abstracts will form the basis for presentations at the College's annual meeting to be held in Anaheim, California, October 26-30, 1975.

Material submitted must not be published or presented elsewhere prior to October 30. Membership in the College is not a prerequisite to participation in the program. Accepted abstracts (200 words maximum) will be published in CHEST, the official journal of the American College of Chest Physicians. Presentations at the Scientific Assembly will be limited to 10 minutes, with an additional two minutes for discussion.

Deadline for submitting abstracts to the College is May 15. All applicants will be notified of the decision of the Scientific Program Committee within six weeks after the deadline.

Submission of abstracts, as well as inquiries on details of requirements, should be directed to W. Gerald Rainer, M.D., Chairman, Scientific Program Committee, American College of Chest Physicians, 911 Busse Highway, Park Ridge, Ill. 60068.

On January 28, 1975, the State of Ohio Medical Board licensed 36 Doctors of Medicine.

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Each Cough Calmer contains:	
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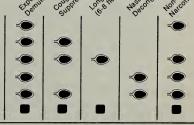
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Glyceryl guaiacolate	50 mg.
Dextromethorphan hydrobromide	10.0 mg.
Phenylpropanolamine hydrochloride	12.5 mg.
Alcohol, 1.4%	_

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Donald G. Vidt, M.D., Cleveland, who is President of the Ohio Society of Internal Medicine, requested that the following statement be published for the education of Ohio Physicians. The Ohio State Medical Journal is pleased to honor Dr. Vidt's request.

APhA-ASIM STATEMENT ON . . . Prescription Writing and Prescription Labeling

Introduction

Historically, the pharmaceutical and medical professions have devoted considerable time and effort to the development and rational utilization of safe and effective drugs for the treatment and prevention of illness. Today, that successful effort continues, helping to achieve the highest standards of health in the world for the American people. But in order to gain maximum benefit from the use of drugs while minimizing their adverse side effects, prescribers and pharmacists must maintain effective communications not only among themselves, but with their patients as well. The directions for drug use and other information which prescribers indicate on prescription orders and which pharmacists transfer to prescription labels are critical to safe and effective drug therapy. In order to assure that this information is conveyed clearly and effectively to patients, the following guidelines have been developed by the American Pharmaceutical Association and the American Society of Internal Medicine.

Guidelines for Prescribers

The following guidelines are recommended for prescribers when writing directions for drug use on their prescription orders.

- 1. The name and strength of the drug dispensed will be recorded on the prescription label by the pharmacist unless otherwise directed by the prescriber.
- 2. Whenever possible, specific times of the day for drug administration should be indicated. (For example, Take one capsule at 8:00 a.m., 12:00 noon, and 8:00 p.m. is preferable to Take one capsule three times daily. Likewise, Take one tablet two hours after meals is preferable to Take one tablet after meals.)
- 3. The use of potentially confusing abbreviations, i.e., qid, qod, qd, etc., is discouraged.
- 4. Vague instructions such as Take as necessary or Take as directed which are confusing to the patient are to be avoided.
- If dosing at specific intervals around-the-clock is therapeutically important, this should specifically be stated on the prescription by indicating appropriate times for drug administration.
- 6. The symptom, indication, or the intended effect for which the drug is being used should be included in the instructions whenever possible. (For example, Take one tablet at 8:00 a.m. and 8:00 p.m. for high blood pressure, or Take one teaspoonful at 8:00 a.m., 11:00 a.m., 3:00 p.m., and 6:00 p.m. for cough.)
- The Metric System of weights and measures should be used.
- 8. The prescription order should indicate whether or not the prescription should be renewed and, if so, the number of times and the period of time such renewal is authorized. Statements such as Refill prn or Refill ad lib are discouraged.

- 9. A separate prescription blank should be used for each drug prescribed.
- When institutional prescription blanks are used, the prescriber should print his/her name, telephone number, and registration number on the prescription blank.

Guidelines for Pharmacists

1. Pharmacists should include the following information on the prescription label: name, address, and telephone number of pharmacy; name of prescriber; name, strength, and quantity of drug dispensed (unless otherwise directed by the prescriber); directions for use; prescription number; date on which prescription is dispensed; full name of patient, and any other information required by law.

2. Intructions to the patient regarding directions for use of medication should be concise and precise, but readily understandable to the patient. Where the pharmacist feels that the prescription order does not meet these criteria, he should attempt to clarify the order with the prescriber in order to prevent confusion. Verbal reinforcement and/or clarification of instructions should be given to the patient by the pharmacist when appropriate.

3. For those dosage forms where confusion may develop as to how the medication is to be administered (for example, oral drops which may be mistakenly instilled in the ear or suppositories which may be mistakenly administered orally), the pharmacist should clearly indicate the intended route of administration on the prescription label.

4. The pharmacist should include an expiration date on the prescription label when appropriate.

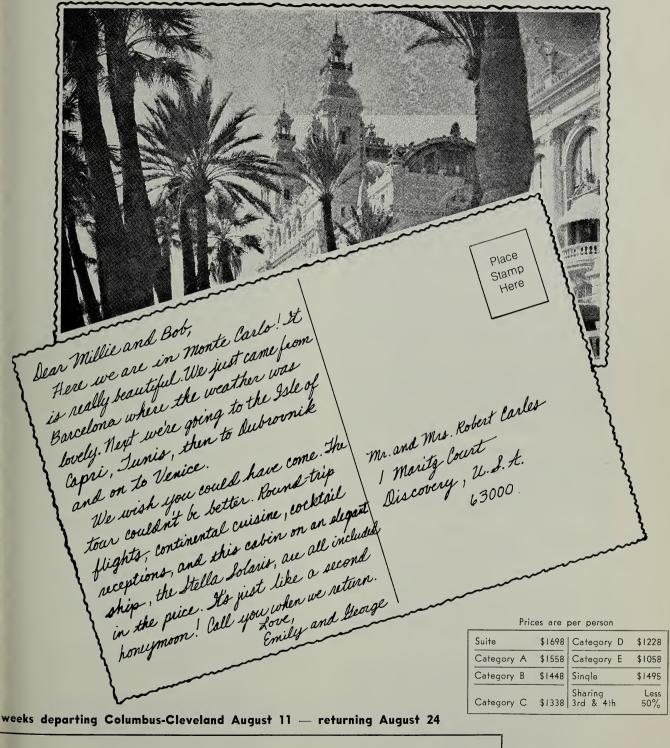
5. Where special storage conditions are required, the pharmacist should indicate appropriate instructions for storage on the prescription label.

Conclusion

Communicating effective dosage instructions to patients clearly and succinctly is a responsibility of both the medical and pharmaceutical professions. Recent studies documenting the low order of compliance with prescription instructions indicate that poor communication between the medical and pharmaceutical professions and poor comprehension by the public may be causative factors.

The American Pharmaceutical Association and the American Society of Internal Medicine believe that the guidelines as stated above will serve as an initial step toward patients achieving a better understanding of their medication and dosage instructions. The two associations urge state and local societies representing pharmacists and prescribers to appoint joint committees for the purpose of refining these guidelines further as local desires and conditions warrant. The associations believe that such cooperative efforts between the professions are essential to good patient care and that significant progress can be made in other areas by initiating discussions between the two professions concerning common interests and goals.

"Here we are in Monte Carlo!"



Adriatic Discovery EDITOR'S NOTE: At the request of the AMA'S Department of Graduate Medical Education, the following Guidelines for housestaff contracts or agreements are published. These Guidelines are not intended as a fixed formula, and are not "essentials."

GUIDELINES FOR HOUSESTAFF CONTRACTS OR AGREEMENTS

Adopted by the AMA House of Delegates at Portland, December 1974

I. Introduction

The "Essentials of Approved Residencies," approved by the House of Delegates in 1970, include a section on relationships of house staff and intitutions. The following outline is intended to promote additional guidance to all parties in establishing the conditions under which house

officers learn and provide services to patients.

Training programs have been central to the process of graduate medical education, which has produced a high level of medical competence in the United States. The American Medical Association recognizes that the integrity of these programs is a primary objective in achieving the best possible care of the the patient. It is, therefore, incumbent upon members of the housestaff and the insti-tutions in which they are being trained to be aware of the parameters and responsibilities applicable to their training programs. In the absence of such awareness, unreasonable expectations may arise to threaten the harmony between hospital and housestaff in the performance of their joint mission.

It should be emphasized that these guidelines are not intended as a fixed formula. Guidelines that seek to cover public, voluntary, and proprietary hospitals necessarily entail so many variables from training institution to training institution that no single form of contract or agreewould be universally applicable. This set of guidelines has, therefore, been developed to cover the more significant substantive provisions of a house staff contract or agree-

The subjects included in the Guidelines are not intended to be the only subjects important or appropriate for a contract or agreement. Moreover, the definition of the respective responsibilities, rights, and obligations of the parties involved can assume various forms: individual contracts or agreements, group contracts or agreements, or as a part of the rules of government of the institution.

II. Proposed Terms and Conditions

A. Parties to the Contract or Agreement

1. Contracts or agreements may be formed between individuals or groups, and institutions. Such a group might be a housestaff organization.
2. The two parties to an agreement or contract may be a single institution or a group of institutions, and an individual member of the housestaff, an informal group of the housestaff, or a formally constituted group or association of the housestaff, as determined by the housestaff organization.

B. General Principles

1. Contracts or agreements are legal documents and must conform to the laws, rules, and regulations to which the institutions are subject. Position, salary and all other benefits should remain in effect insofar as possible without regard to rotational assignments even when the member of the housestaff is away from the parent institution. Exceptions required by law or regulations should be clearly delineated to the house officer at the time of the appointment. Changes in the number of positions in each year of a training program should be made so as not to affect adversely persons already in, or accepted in, that program.

The agreement should provide fair and equitable conditions of employment for all those performing the duties of interns, residents and fellows. When a general contract or agreement is in effect between an association and an institution, individual contracts or agreements should be consistent with it.

2. Adequate prior notification of either party's intent not to renew the contract or agreement should be required, and the date of such notification should be included in the contract or

agreement.

The institution and the individual members of the housestaff must accept and recognize the right of the housestaff to determine the means by which the house staff may organize its af-fairs, and both parties should abide by that determination; provided that the inherent right of a member of the housestaff to contract and negotiate freely with the institution, individually or collectively, for terms and conditions of employment and training should not be denied or infringed. No contract should require or prescribe that members of the housestaff shall or shall not be members of an association or union.

C. Obligation of the Housestaff

1. Members of the housestaff agree to fulfill the educational requirements of the graduate training program, and accept the obligation to use their efforts to provide safe and effective and compassionate patient care as assigned or required under the circumstances as delineated in the "Essentials of Approved Residencies" and previously approved standards of the AMA Council on Medical Education.

2. Members of the housestaff should comply with the laws, regulations, and policies to which

the institution is subject.

D. Obligation of the Institution

1. The institution agrees to provide an educational program that meets the standards of the AMA "Essentials of Approved Residencies."

2. The institution agrees to maintain continuously its staff and its facilities in compliance with all of the standards in the AMA "Essentials of Approved Residencies."

E. Salary for Housestaff 1. The salary to be paid and the frequency of payment should be specified. The salary schedule should be published. The basis for increments and the time of the increments should be specified.

2. In determining the salary level of a member of the housestaff, prior educational experience should be considered, and a determination made as to whether credit should be given.

3. The responsibilities of senior residents should be recognized in salary differentials.

Hours of Work

There should be recognition of the fact that long duty hours extending over an unreasonably long period of time or onerous on-call schedules are not consistent with the primary objective of education or the efficient delivery of optimal patient care. The institution should commit itself to fair scheduling of duty time for all mem-bers of the housestaff, including the provision of adequate off-duty hours.

G. Off-Duty Activities.

The contract or agreement should provide that a member of the housestaff is free to use his offduty hours as he sees fit, including engaging in outside employment, if permitted by the terms of the original contract or agreement, so long as such activity does not interfere with his obligations to the institution or to the effectiveness of the educational program to which he has been appointed.

H. Vacation and Leave

The amount of vacation, sick leave, and educational leave to which each member of the house-

Vacations should be specified.

Vacations should be expressed in terms of customary working days as defined by the institu-

If vacations may be taken only at certain times of the year, this restriction should be stated. Any requirements for scheduling vacation time should also be stated.

Provisions may also cover leaves for maternity, paternity, bereavement, military duty, examinations and preparations thereof, for educational conferences. Reimbursements for tuition and expenses incurred at educational conferences should be considered.

The agreement should set forth any progressive increases in the amount of time allowed for vacations, sick leave, and educational leave. Educational leave should not be deducted from vacation time.

Insurance Benefits

Insurance benefits should be set forth with particularity and should be tailored to the specific

needs of the housestaff.

Some of the more common insurance benefit provisions are (1) hospitalization and basic medical coverage for the member of the housestaff, spouse, and minor children; (2) major medical coverage for the member of the housestaff spouse and minor children; and (3) group. staff, spouse, and minor children; and (3) group life insurance, and dismemberment and disability insurance for the member of the housestaff only.

It should also be specified whether the institu-tion will pay the full amount of premiums or only a portion of the premiums, the balance to be paid by the member of the housestaff. Copaid benefits should be established, separately from other hospital employee benefits, as a means of maximizing benefits.

In some instances, free care for the housestaff and their families at the training institutions may be provided.

In lieu of insurance benefits, the contract or agreement may provide for fixed annual payments to a housestaff association for each member of the housestaff so that the housestaff association may determine and provide for insurance or other benefits for the housestaff.

Professional Liability Insurance

The contract or agreement should specify the amount of professional liability insurance that the institution will provide for each member of the housestaff together with the limits of liability applicable to such coverage.

It might also be appropriate to provide in the contract or agreement that the housestaff and the institution will cooperate fully with the insurance company in the handling of any professional liability claim. K. Committee Participation

Insofar as possible, the institution should agree to provide for appropriate participation by the housestaff on the various committees within the institution. This participation should be on committees concerning institutional, professional, and administrative matters including grievance and disciplinary proceedings. Members should have full voting rights.
Representatives of the housestaff should be selected by members of the housestaff.

Grievance Procedures
The contract or agreement should require and publish a grievance procedure. A grievance procedure typically involves the following:

1. A definition of the term "grievance" (e.g., any dispute or controversy about the interpretaregulation, or any policy or practice).

The timing, sequence, and end point of the

grievance procedure.

 The right to legal or other representation.
 The right of an individual member of the housestaff or a housestaff association to initiate a grievance procedure and the obligation of the housestaff to maintain patient care during the grievance procedure.

. A statement of the bases and procedures for the final decision on grievances (end point), and agreement of both parties to abide by the decision.

6. Should costs arise in the grievance procedure, a prior agreement as to how these costs will be apportioned between the parties.

M. Disciplinary Hearings and Procedures With respect to disciplinary procedures, the provisions of Article VIII—Hearing and Appellate Review Procedure of the JCAH Guidelines for the Formulation of Medical Staff Bylaws, Rules, and Regulations shall be appliable. cable to the housestaff in the same manner as they are to all other members of the medical Appeals Committees shall contain appropriate representation of the Housestaff.

Description of the Educational Program The specific details of the operation of the educational experience should be made available to each prospective candidate. These data should include specific descriptions of training programs, including numbers of resident positions at each level of training, copies of existing housestaff contracts or agreements, approval status of programs to which candidate is applying, methods of evaluation, procedures for grievances and disciplinary action, and commitments for further training.

Patient-Care Issues
The quality of patient-care services and facilities
may be specified in the contract, and could
include such matters as adequate equipment,
bedspace, clinical staffing, and clinical staff structuring.

Other Provisions

The agreement should provide for adequate, comfortable, safe, and sanitary facilities.

The foregoing provisions are not all-inclusive. Depending upon the institution's size, resources, location and affiliations, if any, and also depending upon the relationships between the institution and the housestaff association, other provision may be included, such as:

1. Maintenance of existing benefits and practices not otherwise expressly covered;
2. Housing, meals, laundry, uniforms, livingout and telephone allowances;

3. Adequate office space, facilities, and supporting services for housestaff affairs;

4. Housestaff association seminars or meetings.



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SHIRLEY L. MACCABEE, M.L.S. AND SUSAN E. McCARTHY, M.LN

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What Is MEDLINE?

MEDLINE is the computerized medical literature indexing and retrieval system of the National Library of Medicine. It is an "on-line," "interactive" system, which means that a searcher, using a typewriter-like terminal connected by telephone to the computer at the National Library of Medicine, can type in your subject request and receive a printed bibliography of journal articles in a matter of minutes.

At the present time the MEDLINE system contains approximately 500,000 citations from 2,400 of the world's biomedical journals. These are the same references that are contained in the monthly volumes of Index Medicus and in their annual cumulations. But with MEDLINE you can go through more than three years' worth of Index Medicus with only the effort it takes to contact a MEDLINE center and describe the subject you want searched.

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Mrs. Maccabee and Ms. McCarthy are Reference Librarians at Calder Memorial Library, University of Miami School of Medicine, Miami. This article originally appeared in the November, 1974 issue of the Journal of the Florida Medical Association. It is reprinted with permission. on MEDLINE, one would have to look in three separate cumulations, plus several monthly issues of Index Medicus. Second, each article in the system is assigned an average of 12 index terms, but the article generally appears under only three of those headings in the printed IM. With MEDLINE the article can be retrieved under all 12 headings, so your search can be much more thorough. The third is MEDLINE's most significant advantage: it allows you to pinpoint your subject by searching for a combination of two or more terms. The following examples help illustrate these features:

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2. One researcher was interested in "noise effects on the cardiovascular system." In 16 minutes MEDLINE located and printed 80 citations that resulted from matching 11 cardiovascular terms, assigned to 32,411 documents with "noise" or "sound." A comparable hand search would require scanning well over 12,000 titles.

What else can MEDLINE do?

MEDLINE can locate and print references to all articles by any given author; it can restrict your search to review articles only, to English or other languages, or to a one-year time period. You can specify sex, age group or research with human or animal subjects. There are many additional ways that your librarian or MEDLINE analyst can make the bibliography even more custom-tailored.

Can MEDLINE be used often to keep up-to-date on a subject?

A special file called SDILINE (Selective Dissemination of Information On-Line) contains the most current month of Index Medicus, several

(Continued from page 199)

weeks before the printed issue is available. You can arrange for a MEDLINE center to search your subject in SDILINE automatically each month and send you the bibliography. In this way you are alerted to new articles with no extra effort, and much earlier than if you checked IM regularly by hand.

Who can use MEDLINE?

MEDLINE is available to you as a physician, medical researcher or health professional, whereever you are located. It is especially valuable to rural physicians who may not have frequent access to a large medical library. Indeed, MEDLINE centers are obligated to extend the service beyond their regular clientele to members of the biomedical community at large.

What does the MEDLINE printout consist of?

MEDLINE will first tell you how many citations it found that satisfy your search request. The librarian will either print out the citations for you immediately on the terminal, or they will be mailed directly to you from the computer center. In either case the information you receive will consist of: (1) author(s); (2) title or English translation of foreign title; and (3) source (journal title, volume number, paging, date). This is all the information you will need to procure the articles you want from a medical library.

How can the articles cited by MEDLINE be obtained?

The library at the MEDLINE center where your search is run will have many of the journals you need. You can read them there in the building or photocopy them. If you have borrowing privileges there, the library will make every effort to obtain for you through interlibrary loan photocopies of any articles they do not have. If you have requested your search by phone or mail, the librarian can advise you how to request interlibrary loan photocopies, usually free of charge, through your nearest hospital or health center library. Thus a physician located at a distance from a medical library has access to any article cited by MEDLINE.

Where is MEDLINE?

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(513-872-5627)

Case Western Reserve University
Allen Memorial Library of Cleveland,
Health Sciences Library
11000 Euclid Avenue
Cleveland 44106
(216-368-3640)

Case Western Reserve University School of Library Science Cleveland 44106 (216-368-3500)

Ohio State University College of Medicine, Health Center Library 376 West Tenth Avenue Columbus 43210 (614-422-9810)

Medical College of Ohio at Toledo Library P.O. Box 6190 Toledo 43614 (419-385-7461)

Any physician in the Dayton area who is interested in information concerning the MEDLINE service may contact:

Raymond A. Palmer Medical and Health Sciences Librarian Wright State University School of Medicine (513-223-5343)

How can one arrange to use MEDLINE?

To have a MEDLINE search run you need only visit, telephone or write the center nearest you. If you come personally to the library, the analyst will go over your request with you and decide on the most appropriate subject headings to use.

Why not let MEDLINE help you next time?

Computers have been used to aid in the compiling of bibliographies for some time, and individualized literature searching by computer is not new to scientists. Only in the past two and one-half years, however, has a speedy, convenient literature retrieval system been available to busy physicians who do not ordinarily have the time to come to the library and go through indexes. It is hoped that many more Ohio clinicians and researchers, especially those distant from the large libraries, will take advantage of this invaluable tool for accessing medical literature.

Obituaries

Humberto C. Bautista, M.D., Columbus; University of Mexico, 1954; age 44; died November 26, 1974; member of OSMA and AMA.

Selma Claire Bolstad, M.D., Cleveland; Western Reserve University School of Medicine, 1931; age 64; died December 23, 1974; member of OSMA and AMA.

Chester Arthur Casey, M.D., Ironton; Tufts University School of Medicine, 1917; age 83; died December 29, 1974; member of OSMA and AMA.

Robert George Claeys, M.D., Soldotna; Indiana University School of Medicine, 1944; age 53; died January 21; member of OSMA and AMA.

Lowry C. M. Conley, M.D., Detroit Michigan; Eclectic Medical College, 1913; age 86; died November 28, 1974.

John Franklin Daugherty, M.D., Oxford; University of Cincinnati College of Medicine, 1954; age 45; died January 27; member of OSMA and AMA.

Joseph Baej Filger, M.D., Cincinnati; University of Cincinnati College of Medicine, 1933; age 69; died January 3, 1975; member of OSMA and AMA.

Ben Ami Finkelstein, M.D., Norwalk; University of Zurich, Switzerland, 1935; age 64; died January 3, 1975; member of OSMA and AMA.

Rivington H. Fisher, M.D., Columbus; Queens University Faculty of Medicine, Canada, 1915; age 81; died January 22; member of OSMA and AMA.

Paul Dewey Grove, M.D., Cincinnati; Ohio State University College of Medicine, 1922; age 76; died December 30, 1974; member of OSMA and AMA.

Frank A. Halloran, M.D., Springfield; University of Cincinnati College of Medicine, 1925; age 72; died November 18, 1974; member of OSMA and AMA.

Donald McLeod Harlor, M.D., Cleveland; Ohio State University College of Medicine, 1918; age 82; died January 29; former member of OSMA and AMA.

Wallace Eby Prugh, M.D., Dayton; Hahnemann Medical College of Philadelphia, 1919; age 83; died December 30, 1974; member of OSMA and AMA.

George Ray Roberts, M.D., Leesburg, Florida; Ohio State University College of Medicine, 1934; age 70; died November 12, 1974; former member of OSMA and AMA.

Elgie Raymond Shaffer, M.D., Wareham, Massachusetts; Ohio State University College of Medicine, 1911; age 89; died October, 1974; member of OSMA and AMA.

Alexander H. Sneddon, M.D., Lore City; Jefferson Medical College of Philadelphia, 1927; age 74; died January 26, 1975; former member of OSMA and AMA.

Charles Earl Updegraff, M.D., Willoughby; University of Pennsylvania School of Medicine, 1909; age 91; died January 14; member of OSMA and AMA.

William Sloss Van Fossen, M.D., Columbus; Ohio Medical University, 1906; age 97; died November 29, 1974; member of OSMA and AMA.

Kenneth W. Clement, M.D., Cleveland led a multi-faceted career as a surgeon, scholar, community leader, and politician until his death on November 29, 1974. He was 53 years of age.

Dr. Clement acted as mayoral campaign manager for Carl B. Stokes in 1965 and 1967. Stokes became the first black mayor of a major city in 1967. Dr. Clement was a former vice chairman of the Cuyahoga County Democratic Party and ran unsuccessfully in 1970 in the Democratic primary for the U.S. Senate.

Deeply involved in the civil rights movement, Dr. Clement was a local and national trustee for the National Association for the Advancement of Colored People and the Urban League.

In 1963-64, Dr. Clement was president of the National Medical Association, the organization of black physicians. He was a member of the Nominating Committee of the Cleveland Academy of Medicine and served on its Legislative and Rehabilitation Committees. He also was a member of the American Medical Association, and the Aero Space Medical Society.

Dr. Clement was appointed to the Kent State University Board of Trustees in 1969 by Governor Rhodes. Upon completion of a four-year term earlier this year, former Governor Gilligan had reappointed him to a nine-year term on the board. Dr. Clements also was on the teaching staff of Case Western Reserve University.

President John F. Kennedy appointed Dr. Clement to the National Social Security Advisory Council. President Lyndon B. Johnson later appointed him to the Presidential Appeals Board of the National Selective Service System and the Hospital Insurance Benefits Advisory Council.

Dr. Clement graduated from Oberlin College in 1942 and received his medical degree from Howard University Medical School, Washington D.C. in 1945. He was a Diplomate of the American Board of Surgery and a Fellow of the American College of Surgeons. A trustee and vice president of Cuyahoga County Hospital, Dr. Clement was also president-elect of the medical staff at St. Luke's where he practiced.

Woman's Auxiliary Highlights

MRS. S. L. MELTZER, Communications Chairman 2442 Dorman Drive, Portsmouth 45662

"Comprehensive health education refers to that broad curricular effort designed to impart knowledge regarding health values, attitudes and practices It should consist of planned learning experiences which will assist individuals to achieve desirable understandings, attitudes and practices related to critical health issues." Those are the words of Mrs. S. B. Pfahl, the state auxiliary's dynamic third vice-president and health education chairman.

Words are mighty important, of course, but action is even more so. Fifi Pfahl decided on a pilot program for the "action" and she had the backing of her own Erie County auxiliary. "Show 'em" somehow can often be so much better than simply "tell 'em"! The group zeroed in on health education in the schools in Erie County. These guidelines sparked the way: 1) promotion of school health education meets the fundamental goal of the auxiliary — helping the physician; 2) health problems in to-day's complex society dictate an increasing need for meaningful health education in the schools; 3) an overwhelming majority of public schools do not include health education as a visible part of the curriculum; 4) because of impending legislation, the coming year is a propitious time to promote this particular program.

Accordingly, Mrs. Pfahl's local committee became liaisons — contacting superintendents of all the systems, interviewing them, offering to help implement a comprehensive health education curriculum. In addition, the women worked at pulling together all the health agencies to display and make available to teachers their special programs. "We're dealing with all teachers who teach healthrelated subjects," says Mrs. Pfahl. "This includes home economics, health, and science and we have also included school psychologists and counselors."

A special orientation meeting was set up with school representatives which was chaired by Erie County's health education chairman. There was an intensive follow-up to this orientation. In addition, Mrs. Pfahl met with members of the County Health Department to inform them of the auxiliary's interest in health education in the schools so that their respective efforts might be coordinated and each would have knowledge of what the other is doing.

This is, of course, only a bird's eye view of what the Erie County auxiliary members are doing to promote an outstanding and badly needed program. Both Fifi Pfahl and the Erie County auxilians are to be congratulated for a pilot program that hopefully will be "copied" everywhere! Sure, it takes time and effort and dedication. "Is your program working"? Mrs. Pfahl was asked. She answers with a definite "yes." "This has been a tremendous opportunity," she says. "We've learned much and the schools are so grateful. The more we learn, the more we can give. And, clearly, it's our business to give. . . . ".

Would You Believe It?

Convention is peeping around the corner. With the month of March well-ensconced, can convention time be far behind? Next month's column will highlight what promises to be a learning-fun-happy get-together, with necessary "business" to be sure but much, much else! The dates are May 12, 13 and 14; the city is Columbus; the place is Christopher Inn; the presiding officer will be Charlotte Glueck, state president; the hard-working chair-



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(Continued)

man and co-chairman, Mrs. Donal S. O'Leary and Mrs. Patrick J. Creedon.

Day At The Legislature

Continuing the successful practice of recent years, the state legislation chairman, Mrs. Albert N. May, has designated March 12 as auxiliary-time at the State House. Beginning at 9:30 a.m., members from all over Ohio will meet first at the Sheraton for a general orientation on OSMA, the legislature, bills to be heard in session that day and bills related to medicine of great importance to OSMA. After this introduction by David Rader, the group will move to the State House to attend committee hearings and/or Floor sessions. There will also be, as was done for the first time last year. a luncheon meeting with state legislators as auxiliary guests in the French Pavilion of the Sheraton. The day's grande finale is the "Rap" session conducted by Mr. Rader. This is a very important and meaningful day which no auxiliary member should miss Congratulations to Ingrid May for her in-depth Legislative Bulletin sent out recently to all county presidents, county legislation chairmen and state board members. It is a remarkably comprehensive, informative, up-todate presentation of what is happening (legislatively speaking) on the state and federal levels. I wonder how many hours upon hours upon hours it must have taken Mrs. May to put together such an incredibly detailed report!

Here And There

Franklin County came up with a wonderful way of chasing away the January "blahs" — a "June in January" meeting at the Continental Racquet Club in Worthington. It was a fun day of tennis, swimming in a heated pool, shopping at the French Market and shops on the "Continent" and a special luncheon. However, it wasn't all play and no work! There was an important business session following the luncheon.

The Cuyahoga County auxiliary was recently presented with a Certificate of Recognition by the Ohio Department of Mental Health and Mental Retardation for the group's Fairhill Hospital Bargain Boutique which has been in operation for seven years. "Prime movers" in this dedicated project are Mrs. Edward Kieger, Mrs. Arthur Watkins, Mrs. Edward Zucker, and Mrs. Robert Spurney, each of whom also received an individual award from the Ohio Department of Mental Health. Congratulations. Isn't this what auxiliary is all about?

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AVAILABLE: Bottles of 100, 500,	
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Lederle Symposium on Arthritis; April 6; Sheraton-Columbus Hotel, Columbus; co-sponsored by Ohio Academy of Family Physicians.

Use and Abuse of Injectable Steriods; April 8; 8:15 p.m.; Steubenville Country Club; Annual Trauma Meeting of Fort Steuben Academy of Medicine.

Drug Therapy; April 11; Fallsview Mental Health Center, Cuyahoga Falls; sponsored by Association of Physicians of Ohio;

Family Relations Workshop on Family Dynamics; April 25-27; Salt Fork Lodge, Cambridge; sponsored by Ohio Academy of Family Physicians; \$50 for members; \$65 for non-members.

Biomechanics; April 28-May 2; Cleveland Plaza, Cleveland; sponsored by American Academy of Orthopaedic Surgeons; \$150 for members; \$250 for non-members; \$125 for residents.

Impact of Federal Regulation of the Health Delivery System — May 1-3; a colloquium of the University of Toledo College of Law; for further information, contact William E. Higley II, Associate Editor, Law Review, 2801 West Bancroft St., Toledo 43606.

Adult Foot, Medical and Surgical Management; May 4-7; Stouffer's Cincinnati Inn, Cincinnati; Sponsored by American Academy of Orthopaedic Surgeons; \$200 for MD's; \$150 for AAOS members; \$100 for residents.

Newborn; May 8-10; Miami Valley Hospital, Dayton; co-sponsored by American Academy of Pediatrics; \$75 for members; \$105 for non-members.

Diagnostic Roentgenology; May 27-31; contact: Harold B. Spitz, M.D., Dept. of Radiology, Cincinnati General Hospital, Cincinnati.

Microneurosurgery Symposium; May 29-31; Cincinnati Convention Center; sponsored by Departments of Neurosurgery, The Christ and Good Samaritan Hospital; contact: S. Stuckey, 506 Oak St., Cincinnati 45219.

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Retinoscopy Course; April 9; University of Kentucky College of Medicine, Lexington; \$100.

Current Concepts in Ophthalmology and Neurophthalmology; April 10-11; University of Kentucky College of Medicine, Lexington; \$80.

Sexual Dysfunction: A Behavior Therapy Workshop; April 12-13; contact: B. J. Foster, Temple University, Dept. of Psychiatry, Henry Ave., Philadelphia, Pa. 19129.

Scientific Assembly on Emergency Medicine; April 21-23; Fairmont Colony Square Hotel; Atlanta, Ga.

Recent Progress in Clinical Endocrinology: Physiological Approach to Diagnosis and Treatment; April 21-25; University of Michigan Medical Center, Ann Arbor; co-sponsored by American College of Physicians.

Gastroenterology for Practicing Physicians — April 24-26; sponsored by American College of Physicians; S. S. Kresge Learning Resources Center of Meharry Medical College, Nashville, Tenn.

Seminar on Law and Medicine; April 24-26; University of Kentucky, Colleges of Medicine and Law: Law Building Auditorium; Lexington; \$65.

Selected Topics in Internal Medicine — May 8-10; sponsored by American College of Physicians; Washington Hospital Center, Washington, D.C.

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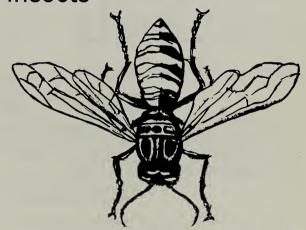
Recent Developments in Medical Oncology; May 12-14; sponsored by American College of Physicians; 19 S. 22nd St., Philadelphia.

Clinical Auscultation of the Heart; May 14-16; sponsored by American College of Physicians; at Georgetown University Medical Center's Gorman Auditorium.

National Symposium on Genetics and the Law; Mav 19-20; contact: Dr. Milunsky, Genetics Unit, Massachusetts General Hospital, Boston 02114; co-sponsored by American Society of Law and Medicine and National Genetics Foundation.

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In This Issue:

Air Force Opportunities188
Allergy Laboratories of Ohio, Inc131
Barry Laboratories
The Brown Pharmaceutical Co., Inc134, 175, 203
Burroughs Wellcome Co154, 169
Capital Financial Services162
Dorsey Laboratories, Div. of Sandoz-Wander, Inc
Geigy Pharmaceuticals173, 174
Immke Circle Leasing
International Travel Advisors, Inc171

Lilly, Eli and Company
Maritz Travel Associates
McNeil Laboratories
Mead Johnson Laboratories
The Medical Protective Company132
Menendian, K.A. Carpets163
Ohio Medical Indemnity179
Pharmaceutical Manufacturers Association
Robins, A.H. Company191-193
Roche Laboratories, Div. of Hoffman- LaRoche, Inc Inside Front Cover, 129, 164, 165, Inside Back Cover, Back Cover
Roerig & Co., Div., Pfizer156
Searle Laboratories, Division of G.D. Searle & Co
SK&F Co., Subsidiary of Smith, Kline & French Laboratories155
St. Anthony Hospital198
Turner & Shepard, Inc
University Center184
Wendt-Bristol Co
Windsor Hospital202

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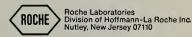
surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of child-bearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies.

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spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.





VOL. 71

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1 License for Common Market

Nine member countries of the European Common Market have adopted a program involving Health Manpower Geographical Distribution. Effective January 1976, the approximately 400,000 practicing physicians in the nine member countries will have the "right to practice" in whatever country they wish.

The program will hopefully provide corrective action for geographical mal-distribution of physicians in the Common Market. However, no corrective action has been proposed to solve the economic factors of the "market place." The average professional medical fee in Belgium is higher than, for example, the average English or Italian fee. One can only speculate about language barriers or the uncontrolled influx of "colonials" through England to the remaining eight member nations. A "Common Market Fee Schedule" may be reasonably anticipated in the future.

The European Common Market action in providing "common licensure to practice medicine" may now be presented by government planners in Washington as a solution to the licensure and relicensure proposed under federal control within United States. (See current proposed Health Manpower legislation which duplicates that passed by both the Senate and House in 1974.)

Gynecologists Meet

Richard L. Meiling, M.D., The Journal's Consulting Medical Editor presided at the Sixth Annual Meeting of the International Society for Advancement of Humanistic Studies in Gynecology. The subject of the meeting, held March 8-14 at Snowmass, Colorado, was "The Impact of Proposed Governmental Legislation on the Practice of Medicine."

Guest Speakers and their topics were:

James C. Corman (Calif.-D), House Ways and Means Committee: "National Health Care-A Democrat's View."

Max H. Parrott, President-Elect of the AMA: National Health Care — The American Medical Association's View."

Chic St. Croix, the International Union of Oil, Chemical and Atomic Workers: "National Health Care—The Union's View."

Theodore C. Marrs, M.D., special assistant to President Ford: "National Health Care—The Administration's View."

H. T. Rhodes, Vice-President, University of Michigan: "Education and the Creation of the Future in Health Care."

Dr. Howard T. Robertson, President, Colorado Medical Association, "State and Federal Legislation—The Professional Liability Crisis."

Blind-Ending Branch of a Bifid Ureter Diagnosed by Intravenous Pyelogram

The Sixth Reported Case

Steven A. Spreen, M.D. Arthur T. Evans, M.D.

> The sixth reported case of a blind-ending branch of a bifid ureter, to be diagnosed by intravenous pyelography, is presented.

BLIND-ENDING BRANCH of a bifid ureter is a most uncommon finding.1-3 It is rare to diagnose this condition on an intravenous pyelogram alone.3 In order to do so, there must be reflux from the intact ureter into the blind-ending branch. Presented herein is the sixth reported case, diagnosed by an excretory urogram. Forty-one cases have been reported diagnosed by retrograde pyelography or at the operating table.

Case Report

A 13-year-old white boy was first seen in the emergency room following a sledding accident in which he slid into a tree and sustained blunt abdominal trauma. Prior medical history revealed one hospitalization for pneumonia and no prior urologic symptoms. The patient's presenting complaint was of lower abdominal pain and mild left flank pain. Physical examination revealed a welldeveloped boy with several small abrasions on his

forehead. Other positive findings were confined to the abdomen, where mild, generalized abdominal tenderness was noted. No costovertebral angle tenderness could be elicited. The white blood cell count was normal, and the hematocrit reading was 39 percent. A voided urine specimen showed a grossly clear urine but, microscopically, it showed red blood cells too numerous to count. Findings from peritoneal lavage and chest x-ray were normal. Cystogram demonstrated a normal bladder contour without extravasation. Intravenous pyelogram showed normal kidneys and collecting systems with no extravasation. There was no extravasation from the ureters. A blind-ending branch of a bifid right ureter could be easily recognized on examination of x-ray film. (See figure.)

The patient was treated with bed rest and the microscopic hematuria cleared in 48 hours. Followup clinic visits revealed no abnormalities.

Discussion

In 1947, Culp described and defined ureteral diverticula.4 He felt that blind-ending bifid ureters should be separated from ureteral diverticula. He stated: "We have elected to place in the group of blind-ending branches of bifid ureters any blindending hollow structure whose lumen joins that of the ureter at a distinct angle, whose wall presents the same histologic coats as the ureter and whose length is more than twice its greatest diameter."

Signs and symptoms of urinary tract infections are probably the most common presenting picture of blind-ending bifid ureters. Pain may also be a presenting symptom, however, there is no symptom which would suggest this diagnosis. 1,2,5,6

Although 46 cases of blind-ending bifid ureter have been reported, it is rare to diagnose this con-

From the Division of Urology, University of Cincinnati Medical Center, Cincinnati, Ohio.

Dr. Spreen, Cincinnati, Resident in Urology, University of Cincinnati Medical Center.

Dr. Evans, Cincinnati, Attending Staff, Christ, Holmes, and Cincinnati General Hospitals; and Professor of Urology, University of Cincinnati College of Medicine.

Submitted August 22, 1974.

dition on intravenous pyelogram alone. Only five previous cases have been noted in the American literature, the most recent reported in July 1973.3 The diagnosis usually is made either by retrograde pyelograms or at the operating table.

Interestingly, Kretschmer reported the only case of bilateral blind-ending bifid ureters.5

Summary

The case of a blind-ending branch of a bifid ureter diagnosed by intravenous pyelogram is pre-



Intravenous pyelogram showing blind-ending branch of bifid right ureter.

sented and, according to available medical literature, it is the sixth case to be reported.

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Jefferson Fracture of the Atlas

A Case Report

Bruce H. Wolf, M.D.

Jefferson fractures of the atlas are quite unusual, but must be diagnosed early to prevent late chronic problems. Serious consideration must be given to this fracture possibility in patients with direct trauma to the top of the head.

ISOLATED FRACTURES of the atlas are rather uncommon, occuring in only 2 to 13 percent of cervical spine fractures.^{1,2} The radiologic literature is replete with discussions of fractures and dislocations of the rest of the cervical spine, but is sparse in noting fractures of the first cervical vertebra. Patients with this type of injury usually have no significant disability. However, vascular injury, cord damage, and death have been reported. 1,3,4

It is the purpose of this paper to present a case of "Jefferson fracture" of the first cervical vertebrae and to review the basic pathophysiology.

Case Report

A 19-year-old man fell and struck the top of his head on a lawn roller in April 1973. Following the trauma, he experienced considerable pain and neck stiffness. Radiographs of the cervical spine were interpreted as normal at the time. He continued to have upper neck pain without localizing neurologic findings.

In November 1973, repeat radiographs, as well as laminograms were obtained. These films, along with the initial study in April, in retrospect, demonstrated definite pathology. On the open-mouth view of the upper cervical vertebrae, there was lateral offset of both lateral masses of the atlas over the axis (Fig. 1).

An oblique view showed the fracture line in the posterior arch of the atlas (Fig. 2). Lamino-

From the Departments of Radiology, Aultman Hospital and Northeastern Ohio Universities College of Medicine.

Reprint requests to Department of Radiology, Aultman Hospital, Canton, Ohio 44710 (Dr. Wolf). Submitted June 3, 1974.



Fig. 1. Open-mouth view of upper cervical vertebrae. Note bilateral overhang of lateral masses of the atlas over the axis.

grams confirmed these observations and showed early degenerative changes at the atlanto-axial joint.

There has been no further therapy for the patient, other than symptomatic analgesics.

Discussion

Fractures of the atlas were first definitively described by Jefferson, in 1920, with a report of four cases and a review of 18 others.⁵ Seven of the



Fig. 2. Oblique view of upper cervical spine. Fracture line is demonstrated in posterior arch of atlas (arrow).

21 isolated atlantal fracture patients died directly from the trauma. Spinal cord damage, as well as vertebral artery injury, have been the cause of death. These fractures often are associated with breaks elsewhere in the cervical spine, especially the

The mechanism of this fracture is a direct blow on the top of the head. 1-3,6 The angle of the articular surface of the atlanto-axial joint transfers the downward force vector from the occipital condyles to a lateral force.8 Lateral disruption of the atlas occurs, most frequently at the junction of the ring of the atlas with the lateral masses. 1,3 If the neck is flexed or extended, this type of fracture is less likely than another break elsewhere.^{3,4}

Clinically, most patients have pain and stiffness in the neck, with restricted movement. As seen in our patient, the diagnosis may not be appreciated on the radiographs. The patient continues with his daily activities, although he may continue to have pain. Occasionally, traumatic arteriovenous fistulae may form.7

When injuries of this area are suspected, careful radiographic evaluation is needed. The openmouth view is best for detecting any abnormality. As in this patient, the lateral masses of the atlas overhang the axis. However, care must be taken not to overread the normal changes that occur on rotation. Unilateral offset may represent normal displacement or rotary subluxation.⁵ Occasionally, rotational views may be helpful. Normal lateral movement of the atlas on the axis may have up to 4 mm lateral overhang unilaterally. 1,9 Lateral and oblique views, as well as laminography, may prove most helpful in demonstrating the fracture.

Conclusion

Fractures of the atlas are quite unusual, but must be searched for. While these are not usually fatal, they may cause chronic pain to a patient. Prompt diagnosis and therapy may help to minimize serious sequelae.

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Editor's Note:

We asked the author if head-tackle football might cause vascular damage. He replied that most of the available literature indicates that this is a somewhat unusual complication of direct trauma to the top of the head. It is his opinion that the more usual complications would be spinal cord injury and possibly a Jefferson fracture as described in this article.

Ex Libris and the Physician

Cecil Striker, M.D.

Ex libris, or bookplates, are an interesting method of recording medical history. A study of several ex libris owned and designed by American physicians is reviewed.

THERE ARE MANY ways of recording medical history. Each has its particular attribute and no attempt should be made to rate the most effective method because, in each instance, they may be of equal quality with only a difference in technique. A similar situation arises with the arts; such as water color versus oil, versus sculpture. Also, one has the written word (biography), medallions, philately, photography, and other techniques.

Bookplates, or ex libris, are an interesting method of recording medical history. Even when designed by physicians or collected by them, they frequently give a very rich portrayal of the designer or collector. In some instances, the personality of the designer shows itself in bold relief also.

What Is a Bookplate?

The most obvious question asked by a novice is: What is a bookplate? It may be defined as any label that can be pasted inside a book as a mark of ownership. The name of such a label is called "ex libris"—from the Latin meaning—from the library.

They vary greatly and range from a single line boxing in the name to a very complicated design. Many are available commercially only requiring an imprint of the name, whereas others are personally designed and may reflect the personality of the designer or may illustrate a medical historical

A bookplate enhances the attractiveness of any book and frequently may be the "enzyme" that initiates the friendship between a bibliophile and a bookplate collector.

Before entering into greater detail, it might be interesting to know the origin of the word "book." Before paper came into use, our forefathers inscribed their letters on wood. The boc, or birch, a close-grained, white wood, was used for this purpose and, hence, the word "book."

Origin and History

Bookplates (ex libris) are a relatively recent form of ownership expression and yet very suggestive marks of ownership have been found in early libraries of Egypt and Assyria. However, the real bookplate originated in Germany early in the 15th century simultaneously with the first printed books. They were woodcuts until 1525. The first plates, dated 1406, were found in a monastery in Swabia (Southwestern Germany). A thin piece of round, soft wood, from an apple, pear, or lime tree was chosen, then later hardwood (boxwood). Then came the copper plate upon which was etched the design. Still later came mezzotints-even later aquatints. Thus, one has in development, woodcuts, wood engravings, etchings, mezzotint, and aquatint engravings.

Ex libris became quite popular and there were well known painters such as Albrecht Dürer, Cranach, and Holbein who designed and executed bookplates, and there is some evidence that they were quite busy.

The earliest known ex libris owned by an American physician was that of Dr. John Jeffries it was an armorial shield but the engraver's name could not be found. Jeffries' claim to fame was that he delivered the first lecture on anatomy in Boston in 1789.

Bookplates in Early America

The earliest bookplates used in the United States were engraved in England about 1703. These were armorial in character but after the Revolutionary War, the native engravers abolished the armorial design and the bookplates became more representative of implements of trade, commerce,

Read before the Annual Meeting of the Ohio Academy of Medical History, Columbus, March 16,

Dr. Striker, Cincinnati, Associate Clinical Professor (Emeritus), University of Cincinnati College of Medicine; Consultant, Internal Medicine, Cincinnati General Hospital; and Past President, Ohio Academy of Medical History.

Submitted July 31, 1974.

agriculture, scrolls, flourishes, and flowers. They varied in size; and one author describes a bookplate one inch square and another large enough to fill the inside cover of a 6X9-inch volume. In other instances, instead of designs, the bookplate has a

short poem and the owner's name on it. For example,

Steal not this book,
My honest friend
For fear the gallow be your
End.



Fig. 1. (upper left) Mens cujusque is est Quisque—The kind of man is everything (Pepys); (upper right) PUGNA PRO PATRIA—Fight for your country (Revere); (lower left) Non est vivere, sed valere, vita—Life is not to be lived but to give value; and (right) Dr. Radbill, pediatrician.

Steal not this book for fear of life, For the owner carries a butcher knife.

Who steals a book that isn't his'n, Soon or late will go to prison. The first known bookplate (ex libris) in America was made in Boston by Nathaniel Hurd

(1730-1777). Little is known about him but the engraved plate part is mostly Chippendale in style and of excellent quality.

Paul Revere and others were contemporary workers with Hurd. I do not own his ex libris but refer you to Figure 1. Be sure to observe the Latin

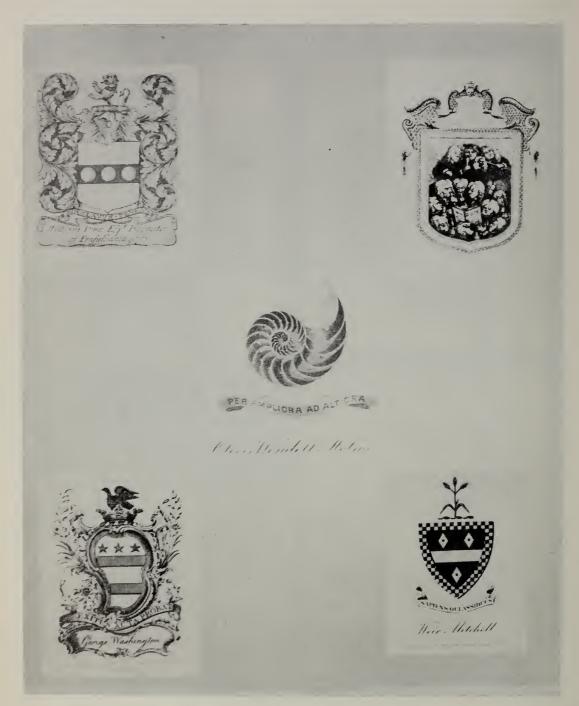


Fig. 2. (upper left) DUM CLAVUM TENEAM—Then may I have the key (Penn); (upper right) Hogarth's caricature of quack physicians; (center) PER AMPLIORA AD ALTIORA—Through honor to the heights (Holmes); (lower left) EXITUS ACTA PROBAT—The end shows the deed (Washington); (lower right) SAPIENS OUI ASSIDUUS—Thinking leads to constancy (Mitchell).

inscription—PUGNA PRO PATRIA (FIGHT FOR YOUR COUNTRY).

Samuel Pepys (1633-1703), of well-known Diary fame, had three bookplates. It was said that he always placed one of them in the front of his book, another at the end (Fig. 2).

Styles and Content

Bookplate inscriptions may have a variety of styles and content. I cite some that may sound humorous but, contrariwise, they may be of serious intent, such as:

My friend! Should you this book peruse, Please to protect it from abuse;
Nor soil, nor stain, nor mark its page, Now give it premature old age;
And when it has effected all,
Please, to return it ere I call.
(unknown)

Far more seemly were it for thee to have Thy study full of books than thy purses full of money (Lilly)

The bookplate of George Washington was a Chippendale or Rococo Armorial plate with the motto *EXITUS ACTA PROBAT* (The end shows the deed). Incidentally, it has been forged several times and placed in books making it appear that the book belonged to George Washington (Fig. 2).

Bookplates can be roughly tabulated as fol-

lows:

Early Armorial (1500-1700) Jacobean (1700-1740) Chippendale or Rococo (1740-1775) Wreath, Ribbon, or Festoon (1775-1800) Modern Armorial (1800-1905) Modern (1905-)

> (from Lord de Tably) English poet 1835-1895

To show what variations there may be and how ludicrous some may become, one drawn by a physician is described as consisting of a sketch of a man standing beside a tombstone and resting his elbow on top of the stone which is on a grave—certainly ludicrous as well as profane. I do not have a copy of this particular bookplate.

On the other hand, however, one may see beautifully designed ex libris such as the one owned by Oliver Wendell Holmes (Fig. 1). It is one of a nautilus shell taken from his favorite poem, *The*

Chambered Nautilus:

Build thee more stately mansions, O my soul. As the swift seasons roll!

Leaving thine outgrown shell by life's unresting sea!

Some Physicians' Ex Libris

Bookplates executed by physicians date back to early American history. In the Library of the College of Physicians in Philadelphia, there is one as far back as November 10, 1734, owned by J. Brett of Boston. Benjamin Rush's had an Armorial Chippendale style. It bore the motto in Latin for "I learn to help the afflicted." Fred Banting, of insulin fame, had on his ex libris the picture of the laboratory where he discovered insulin.

In acquiring many of these ex libris, the donor has been most kind in sending me a warm letter of explanation and also has sent very interesting information which, if it were possible to combine, would make an interesting and very informative document. The following are a few of them.

When the famous Dr. Wilder Penfield, whom many of you may or may not recall, was a Nobel Prize winner for localizing the memory center, accompanied his ex libris with a very long and interesting letter. Here is a partial quote: "This bookplate was designed by R. P. Tristran Coffin in 1920 when he and I were fellow students at Oxford. He was later called the poet of Maine. The Coat of Arms are Milwaukee Downer College from which my wife, Helen Kermott Penfield, graduated. The Princeton, Oxford and Johns Hopkins Coat of Arms are ones where I was harboured for varying years." (See Figure 3.)

Samuel X. Rabill, M.D. of Philadelphia wrote me: "I have been gathering bookplates for over 40 years and have collected thousands of them, mostly medical. I have designed and use several but have no explanation for doing this." I have picked a few of his because they are very attractive and they embody a considerable amount of information for their size. (See Figs. 1 and 2.)

Dr. Florence Sabin (1871-1953) was an American anatomist at Johns Hopkins University 1902-1917, later was professor of histology 1917-1925, and after retirement, was associated with the University of Colorado from 1925 on. Her histological studies were epochal (Fig. 3).

Dr. Weir Mitchell of Philadelphia (1829-1914) was a very famous surgeon of the Union Army during the Civil War and specialized in diseases of the neurological system. He was the first to discover what was called "nervous breakdown." He also was famous for his writing of poetry and fiction. A few are listed: "The Hill of Stones," "A Psalm of Death and Other Poems," "Tragedy of the Sea," and "The Autobiography of a Quack." (See Figure 2.)

Dr. J. C. Brougher, whom I do not know, uses a quotation in his ex libris from Ayer's American Almanac of 1881. (See Figure 4.)

On his ex libris, Dr. Paul D. White had a physician of antiquity seated in his library with foxglove plants (digitalis) on either side, symbolizing the heart specialist.

One of the most amusing bookplates was one used by a physician from Massachusetts. Hogarth's caricature of a group of famous 18th century En-

glish quacks in consultation was called, "The Undertakers' Arms" (Fig. 2).

Purpose of Bookplates

Obviously, the principal use of an ex libris is to insure the return of the book to the owner.

This type of bookplate disappeared with the rapid increase of very original and artistic ex libris. Now, these are used as a method of establishing ownership, as a work of art, and very frequently, as a record of medical history. They even reflect the character of the designer and/or owner. If one

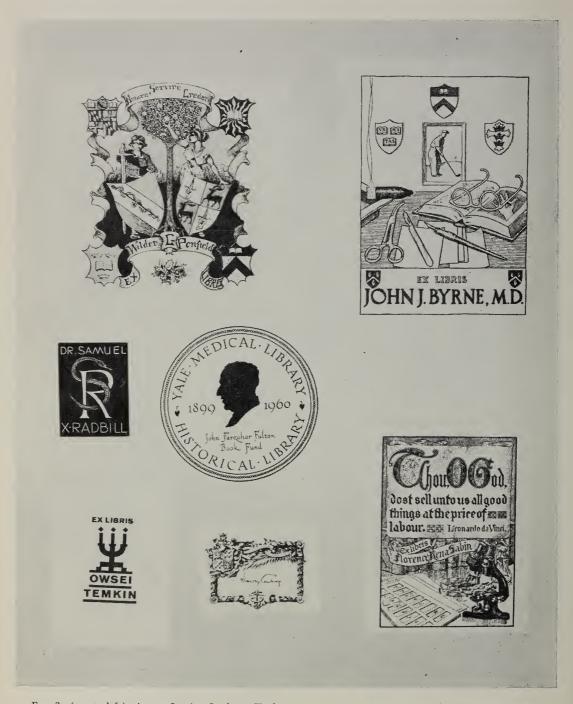
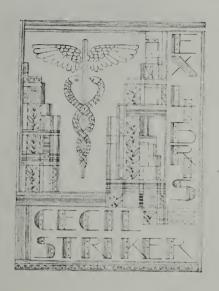


Fig. 3. (upper left) Amare Servire Credere—To love—to serve—to believe (Penfield); (upper right) self-designed plate of Dr. Byrne, orthopedist, golfer, cigar smoker; (center left) caduceus designed by Dr. Radbill; (lower center) Virtute et numinis—Virtue and godliness (Cushing); and (lower right) plate of Dr. Sabin, microscopist.

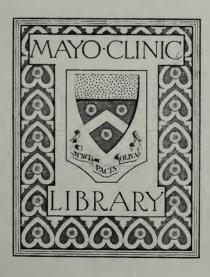
assembles a group of bookplates (ex libris), it is not too difficult to make such identifications (Fig. 4).

Curtin said: "Bookplates are frequently bought and sold. The value may depend upon the age or rarity, the popularity, or eminence of its owner, the reputation of the designer or engraver, the artistic skill shown and finally upon the ingenuity, novelty or oddity of the design."

The author has over 600 ex libris either designed or owned by physicians—indeed a rewarding hobby. As stated at the outset, this all-encompassing







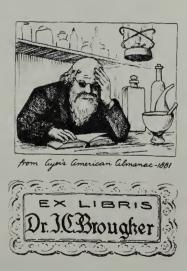


Fig. 4. (upper left) abstract designed by author's wife; (upper right) abstract designed by author's wife for their son; (lower left) uniform design used for Mayo Clinic with only department name changed; (lower right) from Ayer's American Almanac-1881 with owner's name inserted.

hobby may offer great reward from an artistic, medical historical, or general knowledge viewpoint.

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- 2. Correspondence. Address all correspondence relating to publication of scientific papers to: The Editor, The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215.
- 3. Manuscripts. (a). Manuscripts should be submitted in the original on standard 22X28-cm (8½X 11-inch) white typing paper.
 - (b). A copy of the manuscript should be retained by the Author.
 - (c). The entire text including case reports and lists of REFERENCES should be TYPED DOUBLE OR TRIPLE SPACE with margins of at least one inch on all sides.
 - (d). Tables, charts, and figures (illustrations) should be submitted separately from the text. They should be identified by number and by concise, descriptive titles. In the text, reference to them should be made by number, eg, (Fig. 1). No charge will be made for reproduc-ion of tables and other tabulated matter that can be set in type.
- 4. Illustrations. (a). Illustrations requiring engraving (photographs, drawings, graphs, etc.) will be submitted to an engraver for an estimate of cost. The Journal will assume \$25 of this expense and the author will be billed directly by the engraver for the remainder.
 - (b). Each illustration should bear the figure number and the author's name on the back. When pertinent, the top of the photograph should be indicated. Do not clip, write on the back with a hard pencil, or otherwise mutilate the prints. (c). Legends for the figures should be

written on separate paper.

(d). The author must affirm that he has written releases on all photographs in which pa-

tients can be identified.

- 5. Abstracts. A short (135-word maximum) abstract should be included with the article. It should cover the main points so that the reader may readily obtain the gist of the article.
- 6. Summaries. The summary should be a concise restatement of the information given in the body of the article.

- 7. References. (a). Lists of references should be at a minimum to conserve space and expense and limited to those essential to the subject and to which actual reference is made in the text. The Editor reserves the right to reduce the number when neces-
 - (b). References should be listed in the order of their appearance in the text.
 - (c). Authenticity and accuracy are the responsibilities of the Author.
 - (d). Each journal reference should include, in this order: Author's last name and initials, title of article, name of journal (abbreviated in accordance with standard usage), volume number, inclusive page numbers, and year.
 - "2. Doe J, Roe RX: How to go about it. Ohio State M J 13:24-30, 1920"

Each textbook reference should include, in this order: Author's surname and initials, title of the book (capitalize all main words), edition, place of publication, name of the publisher, year of publication, volume, if more than one has been published, and page.

"5. Osler W: Modern Medicine, ed 3 Philadelphia, Lea & Febiger, 1927, vol 5, p 66."

- 8. Identification of Patients. Names, initials, hospital numbers, or any other identifiable labels, should not be used. It is preferable to identify patients for the purpose of publication by the use of numbers in series for the study being reported.
- 9. Metrication. All measurements must be in metric units. English units should be given in parentheses following the metric in all cases where the measurement was originally done in English units.
- 10. Reprints. An order blank for reprints with a table covering cost will be sent with the galley proof to the Senior Author.
- 11. Editorial Assistance. The Journal staff stands ready to assist the Author in preparing his manuscript. For his own assistance, however, the Author is encouraged to consult standard texts on medical writing, such as the Style Book and Editorial Manual, prepared by the Scientific Publications Division, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Dr. Bates, Toledo,Is Candidate ForOSMA President-Elect



IN ACCORDANCE WITH Section 3 of Chapter 5 of the OSMA By-laws, the following nomination of a candidate for the office of President-Elect of the Ohio State Medical Association has been filed with the Executive Director 60 days prior to the meeting of the House of Delegates at which the election is to take place.

The Academy of Medicine of Toledo and Lucas County

> Toledo, Ohio October 8, 1974

Mr. Hart Page, Executive Director Ohio State Medical Association 600 South High Street Columbus, Ohio 43215

Dear Mr. Page:

By Constitutional privilege, we are pleased to nominate George N. Bates, M.D., the Fourth District Councilor, as a candidate for the office of President-Elect of the Ohio State Medical Association.

Dr. George N. Bates is qualified by membership in good standing in The Academy of Medicine of Toledo and Lucas County, the Ohio State Medical Association and the American Medical Association.

Respectfully submitted

John C. Kelleher, M.D. President

C. Douglass Ford, M.D. Delegate

CURRICULUM VITAE

George N. Bates, M.D., born in Morrisville, Vermont, June 24, 1916, a son of Dr. George L. and Mary Elizabeth Walsh Bates. He attended public schools there and in Florida, graduating from Peoples Academy of Morrisville, Vermont, in 1933. He received his premedical degree from the University of Notre Dame in 1937. Medical education followed at the Faculty of Medicine, McGill University, Montreal, Quebec, Canada, where he was awarded the M.D.-C.M. degree in 1942.

He remained in Montreal for his internship and some residency training in surgery at St. Mary's Hospital, then continued his residency training in surgery at St. Vincent Hospital in Toledo.

For many years, Dr. Bates was associated with the late E. J. McCormick, M.D., a past-president of both the Ohio State Medical Association and the American Medical Association. Following Dr. McCormick's retirement, Dr. Bates and Frank E. Foss, M.D. enjoyed a lengthy surgical association. Currently, he is the Fourth District Councilor of the Ohio State Medical Association and is an alternate delegate from the OSMA to the AMA. On the OSMA Council he serves as Chairman of the Auditing and Appropriations Committee as well as the Council Fee Review Committee.

Dr. Bates has served as secretary, vice-chief and chief of the Medical Staff of St. Vincent Hos-

pital and Medical Center. He has been a member in one capacity or another of the surgical staffs of St. Vincent, Toledo, Mercy, St. Charles and Flower hospitals. He is a diplomate of the National Board of Medical Examiners (1944), Fellow of the American College of Surgeons (1950), Fellow of the International College of Surgeons (1954), and diplomate of the American Board of Surgery (1952). He is a member and past secretary of the Academy of Medicine of Toledo and Lucas County; also a member of the Ohio State Medical Association, the American Medical Association, the Pan American Medical Association and the American Occupational Medical Association. Further, Dr. Bates has been both Secretary and President of the Ohio State Surgical Association. He is a member of the Ohio Chapter of the American College of Surgeons and the Toledo Surgical Society. In addition, he is a clinical associate at the Medical College of Ohio at Toledo.

Dr. Bates has served on the Board of Directors of both the Toledo Speech and Hearing Center and the downtown Lions Club. He is a past member of the Board of Trustees of the Health Planning Association of Northwest Ohio. He is a member of the President's Council on Physical Fitness. He holds the Commission of Medical Director in the United States Public Health Service Reserve.

Dr. Bates, Corporate Medical Director of Owens-Illinois, Inc. an employer of 80,000 worldwide, is married to the former Louise LeSage of Montreal. They have 6 children and 2 grandchildren. Dr. Bates is a longtime member of Gesu Parish in Toledo.

Residency Quality: Top Priority

The retiring president of the American Board of Family Practice urged his colleagues on the certifying body in the new specialty of family practice to (1) play a major role in upgrading and maintaining the quality of residency training in the specialty, and (2) adopt a stance of public advocacy in the delivery of health care.

Dr. Arthur Nelson, Scottsdale, Ariz., made his report to the 15-member board at its annual meeting at Carlsbad, Calif. The ABFP, founded in 1969, has held five examinations and now numbers more than 7,000 diplomates.

The board was the first certifying unit to require recertification and is the only such body to have voting members from associated specialists. It includes representatives from internal medicine, pediatrics, obstetrics/gynecology, surgery and psychiatry/neurology, as well as family practice.



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Indications: Pro-Banthīne is effective as adjunctive therapy in the treatment of peptic ulcer. Dosage must be adjusted to the individual.

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Warnings: Patients with severe cardiac disease should be given this medication with caution. Fever and possibly heat stroke may occur due to anhidrosis.

Overdosage may cause a curare-like action, with loss of voluntary muscle control. For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted. Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthīne.

Precautions: Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

Dosage and Administration: The recommended daily dosage for adult oral therapy is one 15-mg, tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

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The Attack on Oral Diabetes Drugs

Manuel Tzagournis, M.D.

Professor of Medicine Division of Endocrinology and Metabolism The Ohio State University College of Medicine

On January 28, 1975, Dr. Charles Sammons, Executive Vice President of the AMA, stated: "A considerable body of expert scientific opinion contradicts these public findings." ie, the findings of The University Group Diabetes Program (UGDP). We have asked Dr. Manuel Tzagournis to comment for both physician and patient involved in diabetic management. His comments are found in this Guest Editorial. See also W.M. Hubbard, M.D., Letter to the Editor, subject "The UGDP Study," JAMA, March 17, Vol. 231, No. 11, page 1133.

-R.L.M.

IT BECOMES WEARISOME to repeatedly respond to sensational news articles, television specials, and "expert" opinions attacking medical practices and physicians. But it is necessary to respond, lest busy individuals simply accept these items as fact.

To illustrate, leading U.S. newspapers lost no time in denouncing drugs being taken by 1.5 million Americans on the basis of one controversial study. Scattered news items appeared in several papers recently culminating in an article in The Wall Street Journal, January 28, 1975, entitled "Oral Diabetes Drugs Danger to Patients Confirmed in Study." The report concerned a biometric committee analysis on the University Group Diabetes Program or UGDP. The news preceded the report to the scientific community, reminiscent of similar leaks to the press which preceded the original report of the UGDP in 1970. Once again the phones began to ring at physicians' offices. Mail trickled in with attached articles on the dangers of a drug prescribed for the diabetic patient. Most of the patients did not understand that this most recent study was another analysis of the original controversial UGDP study.

The original UGDP findings, that the oral hypoglycemic agents might cause premature deaths from heart disease, were rejected for the most part by most of the scientific and practicing community of physicians. Otherwise, why would their use expand steadily since the original report in 1970? Surely, there was no scarcity of discussions at scientific meetings on the pros and cons of this study. Nor was there a lack of written communications in the scientific media on the subject. Interestingly, people in most other countries in the world, including Canada and Great Britain, likewise read the report and continued to use the drugs.

This revisit of the diabetic drug controversy stems from the special contribution in *The Journal of the American Medical Association*, February 10, 1975. The article is accompanied by an editorial expressing relief that the UGDP controversy is now settled. The editorial is written by T. C. Chalmers, M.D., hardly an unbiased observer since he chaired the policy advisory board of the UGDP.²

In the way of background, the cooperative study reported in 1970 that "tolbutamide and diet may be less effective in prolonging life than diet alone." In 1971, the UGDP reported that treatment with phenformin also resulted in excess cardiovascular deaths. Numerous criticisms of the study were voiced in papers and meetings directed at its design, randomization of patients, statistics, and interpretation of findings. Accordingly, the National Institutes of Health (NIH), which financed the study to the tune of about \$8 million, appointed a committee to make an assessment of the quality of the study, particularly the biometric aspects of it. In January 1975, they reported that the UGDP trial "has raised suspicion that cannot be dismissed on the basis of other evidence presently available."

Several years ago, in the fury of finding risk factors for the development of coronary disease, a report appeared showing a significant correlation between cardiovascular mortality and the ownership of a color television set. It is doubtful that intensive reanalysis and reassessment of the raw data would alter that association statistically. The analogy is far fetched, but would any reasonable scientist urge that the use of color television be limited or stopped as has been urged with the oral hypoglycemic agents? Of course, concomitance is not causation.

(Continued on Page 232)



Bioequivalence

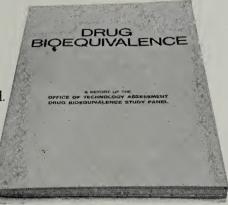
the weight of scientific opinion:

If the pharmacist substituted a chemically equivalent drug for the one you have specified for your patient—could you be certain of that product's safety and effectiveness simply because the chemical content was the same?

Definitely not, unless bioequivalence tests and other quality assurance checks had been conducted. The pharmaceutical industry and many scientists have maintained this position for years, but others have questioned it. Now the Office of Technology Assessment of the Congress of the United States has reported on the issue in its Drug Bioequivalence Study.*

Here are a few definitive statements in the O.T.A. report:

"...the problem of bioinequivalency in chemically equivalent products is a real one. Since the studies in which lack of bioequivalence was demonstrated involved marketed products that met current compendial standards, these documented instances constitute unequivocal evidence that neither the present standards for testing the finished product nor the specifications for materials, manufacturing process, and controls are adequate to ensure that ostensibly equivalent drug products are, in fact, equivalent in bioavailability.



"While these therapeutic failures resulting from problems of bioavailability were recognized and well documented, it is entirely possible that other therapeutic failures and/or instances of toxicity that had a similar basis have escaped attention."

The Pharmaceutical Manufacturers Association supports federal legislative amendments that would require manufacturers of duplicate prescription pharmaceutical products, subject to new drug procedures, to document:

(a) chemical equivalence; and

(b) biological equivalence, where bioavailability test methods have been validated as a reliable means of assuring clinical equivalence; or (c) where such validation is not possible, therapeutic equivalence.

In addition, the PMA supports federal legislation that would require certification of all manufacturers of prescription products before they could start in business, annual inspections and certification thereafter, and strict adherence to FDA regulations on good manufacturing practices.

The overall quality of the United States drug supply is excellent. But only a total quality assurance program, envisaged in these and other policy positions adopted by the PMA Board of Directors in 1974, can bring about acceptable levels of performance by all prescription drug manufacturers and thereby assure the integrity of your prescription...



Pharmaceutical Manufacturers Association 1155 Fifteenth Street, N.W. Washington, D.C. 20005

*Copies of the complete report on Drug Bioequivalence may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

protecting the integrity of your prescription

To leap from statistical validation of a controversial clinical trial to extrapolation that the oral hypoglycemic agents might cause "10,000 to 15,000 unnecessary deaths each year in the United States alone"2 borders on irresponsibility. In the supposed interest of helpless patients, news, more properly propaganda, has flooded the communication media. In a free intellectual environment, scientific claims should be placed in the proper perspective; as observations to be examined, confirmed, and accepted by physicians. Unfortunately, certain ideas in this day and age move in tenacious circles fueled by sensational news and television specials and anything which fits the bill, no matter how outrageous or absurd, can count on incredible longevity.

Before accepting the conclusions of the UGDP study, several bothersome questions must be answered. For example, what is the nature of the toxicity of two entirely different hypoglycemic agents with different mechanisms of action which result in the same premature death due to cardiovascular disease? It is pointed out by some that it might be tolbutamide's positive inotropic effect on the heart. But digitalis, isuprel, L-dopa, and many other drugs have a positive inotropic effect. More importantly, tolbutamide probably has no inotropic effect on the heart of intact man.3 It might be more fruitful to point out that the placebo and insulin groups (with whom the drug patients were compared in the UGDP study) had fewer deaths than that predicted for all the U.S. population by age and sex. Imagine, a group of diabetics who were, on the average, overweight, hyperglycemic, and hypercholesterolemic survived better than their overall U.S. counterparts. Tell that to the insurance companies! At the same time, explain how not one single individual from a total of 205 (mean age of 52 years at entry) who took placebo died of myocardial infarction at the end of the eight-year study.

Another question is whether other clinical investigations support the UGDP conclusions. If it is true that tolbutamide or phenformin is related to increased cardiovascular mortality, then other prospective studies should tend to confirm or reject the scientific validity of that hypothesis. I know of no other prospective study dealing with the oral hypoglycemic agents which supports or confirms the UGDP findings. In fact, prospective studies conducted in Great Britain,4 Sweden,5 California,⁶ The Ohio State University,⁷ and Framingham⁸ not only fail to confirm the UGDP findings, but some tend to suggest a protective effect on vascular disease by the oral agents. It is probable that oral agents are neither beneficial nor detrimental to vascular disease. The control

of blood glucose by drugs is desirable for many reasons other than vascular disease alone.

There is absolutely no objection to the presentation of all the data and interpretations by the UGDP group to the scientific community. This study was a large, well-conducted one. It served to caution us in the long-term treatment of a chronic disease. That is desirable. It prompted many of us to work harder to encourage diabetic patients to diet before prescribing insulin or oral agents.

I do object, however, to the attempts of some experts to ram their conclusions down our throats. I object to the repeated efforts to gain the support of Federal agencies to impose their will on the rest of the practicing physicians. I object to their implications that all of the oral hypoglycemic agents are dangerous when, in fact, their study dealt with only two of the drugs. And, I object vigorously to the steady stream of publicity to the lay media which can only serve to confuse our patients and further fragment an already delicate doctor-patient relationship.

As S. I. Hayakawa wrote in an article Is Television News Propaganda?: "It is always important to distinguish fact from propoganda. It is always difficult to find the needle of meaning in haystacks of nonsense, the slices of real beefsteaks in the carload of bologna."

I simply urge — give us the facts — the truth will surely evolve from objective reasoning, confirmation, and good sense. Let all interested people work quietly in their laboratories on this problem, reporting intermittently to their colleagues on their progress, and in time, the truth will become quite obvious to all.

Manuel Tzagournis, M.D.

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Proceedings of The Council Meeting of March 8-9, 1975

A REGULAR MEETING of the Council of the Ohio State Medical Association was held Saturday and Sunday, March 8 and 9, 1975, at the Columbus Headquarters' Office, 600 S. High Street, Columbus, Ohio.

Those present Saturday were: All members of the Council, with the exception of Dr. Pichette; Dr. John H. Budd, Cleveland, AMA Board of Trustees; Mr. James E. Pohlman, Esq., Columbus, OSMA Legal Counsel, and Messrs. Page, Edgar, Gillen, Campbell, Clinger, Rader, Houser, Holcomb, Mulgrew, Mrs. Wisse and Mrs. Dodson, of the OSMA Staff.

Those present Sunday were: All members of the Council, with the exception of Dr. Pichette; Dr. William Dorner, Akron, President of the Summit County Medical Society; Dr. Rocco Antenucci, Mogadore, President-Elect of the Summit County Medical Society; Mr. Pohlman, and Messrs. Page, Edgar, Gillen and Holcomb, of the OSMA Staff.

The meeting was called to order by President

Henry.

The minutes of the February 1-2, 1975 meeting of the Council were approved.

Membership

Mrs. Wisse reviewed membership statistics. Mr. Page announced that the American Medical Association Membership Department has reported the \$60 AMA assessment has been paid by 84,000 members as of March 4, 1975.

The Council directed that names of newly licensed medical doctors in Ohio be forwarded by Mrs. Wisse to the appropriate county medical societies, with copies to the district councilor.

Fiscal Matters

Dr. Bates presented the minutes of the Committee on Auditing and Appropriations meeting of March 8, 1975.

The minutes included a recommendation that the Ohio State Medical Association Scholarships be changed in name to "The Thomas E. Rardin Family Practice Scholarships."

The minutes were approved.

American Medical Association

Dr. Budd reported on activities of the American Medical Association. He discussed professional liability insurance problems; the AMA assessment; National Health Insurance proposals; proposals for continuation of health insurance for unem-

ployed persons; the AMA lawsuit on concurrent review and possible future suits on "MAC" (maximum allowable cost for drugs) and on the National Health Planning Act.

A proposed letter from the co-chairmen of the Ohio AMA Delegation to the chairman of the Special Committee of the AMA House of Delegates was presented to the Council. The Council withheld approval of the letter and asked the delegation officers to collaborate on another approach to the communication.

A proposed resolution for the AMA House of Delegates, with regard to scrupulous separation of AMPAC and AMA, submitted by the chairman of the Ohio Medical Political Action Committee was discussed by the Council.

The resolution was approved for submission, subject to minor amendments to be worked out with the OMPAC Chairman, Dr. H. William Porterfield.

Professional Liability

A general discussion of the professional liability crisis was held. The positive response from the OSMA membership regarding President Henry's recent communications was noted. Mr. Harry V. Jump, Director, Ohio Department of Insurance, will conduct a meeting on March 11, 1975, to consider all aspects of a remedial, unified program, basically legislative. OSMA will be one of the primary contributors in this effort. The remedial, unified program will also include input from the Ohio Department of Insurance, Ohio State Bar Association, Ohio Osteopathic Association, Ohio Hospital Association, and professional liability insurance carriers.

It is anticipated that the legislative program will be introduced in the very near future and, at that time, county medical society and individual member contact with legislators will be vitally important to the success of the legislative program.

OSMA Annual Meeting

Resolutions submitted for consideration of the OSMA House of Delegates were presented to the Council.

It was announced that, in accordance with the action of the House, members would be offered the opportunity to request copies through the OSMAgram.

(Continued on Next Page)

(Continued)

Resolution packets will be distributed to OSMA Delegates, Alternate-Delegates, Presidents and Secretaries in advance of the Annual Meet-

The following resolution was adopted by the Council for submission to the OSMA House of Delegates:

OSMA Position on PSRO

(By The Council of the OSMA)

WHEREAS, The medical profession has traditionally been dedicated to preserving and maintaining the highest quality medical care and appropriate level of care, and

WHEREAS, the medical profession has traditionally supported self-regulatory bodies and programs, and

WHEREAS, Physician Peer Review Systems and programs have been a long standing part of the self-regulatory programs to ensure appropriate quality and appropriate level of care, and

WHEREAS, accountability is a recognized characteristic in contemporary society, and

WHEREAS, confusion has developed as to the proper meaning and construction to be given to previous resolutions adopted by the House of Delegates concerning PSRO, MAI-Peer Review Systems, and P.L. 92-603, be it, therefore,

RESOLVED, that the House of Delegates instruct the Council to continue its efforts in cooperation with other state medical associations and the American Medical Association, to achieve constructive amendments to P.L. 92-603 and to ensure appropriate regulations and directions by the Secretary of HEW, with particular emphasis directed at amending those sections of the law that present potential dangers in the areas of confidentiality, professional liability, development of norms of practice, quality of care, and the authority of the Secretary of HEW; and be it further

RESOLVED, that the Ohio State Medical Association should, in cooperation with other state medical associations and the AMA, continue its efforts to achieve legislation that allows the medical profession to perform peer review in accordance with the profession's philosophy and in the best interests of the patient; and be it further

RESOLVED, that the House of Delegates direct the Council to request M.A.I. to continue its consultative and supportive role, and its work in developing medically oriented Peer Review Systems, criteria, methodologies and programs, in assisting county medical societies and individual members of OSMA who elect to participate in the development and operation of clinical Peer Review Systems, including, but not limited to, programs which implement the review provisions of P.L. 92-603, and be it further

RESOLVED, that component county medical societies and/or individual members of OSMA who elect not to participate in the implementation of P.L. 92-603 should not be preccluded from adopting and maintaining such a position by this resolution, but should be encouraged to develop effective non-PSRO peer review programs that embody the principles endorsed by the medical profession as constructive alternatives to PSRO; and be it further

RESOLVED, that, if ongoing evaluation of the PSRO program by the House of Delegates and/or the Council reveals that it adversely affects the quality of patient care or conflicts with the principles of medical ethics, the Council is instructed to use all legal means to rectify such shortcomings of the PSRO program; and be it further

RESOLVED, that this resolution shall supercede all previous resolutions adopted by the House of Delegates on these subjects including, but not limited to, Sub. Res. No. 6-71, Sub. Res. 16-72, Sub. Res. 26-72, Sub. Res. 29-73, Am. Sub. Res. 28-74.

Ohio Medical Indemnity, Inc.

Dr. Clarke reported that the nominating committee had recommended that the following persons be nominated and elected to the OMI Board of Directors for the ensuing year: Ben Arnoff, M.D., Columbus; Dwight L. Becker, M.D., Lima; William T. Blair, Columbus; Guerney H. Cole, Jr., Middletown; Joseph Cionni, M.D., Cincinnati; W. D. Henceroth, D.O., Grove City; Paul N. Ivins, M.D., Hamilton; Paul A. Jones, M.D., Zanesville; Robert A. McLemore, M.D., Springfield; William E. Sovik, M.D., Youngstown; James B. Ogden, Columbus; Martin R. Otto, Warren; Robert Hetterick, Cincinnati; James G. Roberts, M.D., Akron; Frank D. Robinson, Canton; Robert N. Smith, M.D., Toledo; L. Eugene Duff, Lima; Phillip W. Tefft, Columbus; M. M. Thompson, M.D., Toledo; William R. Schultz, M.D., Wooster; William M. Wells, M.D., Newark.

By official action, the Council approved the nominations presented and authorized the following persons to cast the votes of the Ohio State Medical Association, a stockholder, at the annual stockholders' meeting, including the election of directors placed in nomination by Council at this meeting on April 23, 1975: Oscar W. Clarke, M.D., Gallipolis, or James L. Henry, M.D., Grove City, or Maurice F. Lieber, M.D., Canton, or Robert G. Thomas, M.D., Elyria, or Mr. Hart F. Page, Columbus.

On behalf of the Council, the President was authorized to thank the retiring directors for their past service: Dr. Robert J. Hasl, Dr. John C. Melnick, Mr. Usher B. Redmann, Mr. Wendell D. Stewart and Dr. Gordon M. Todd.

Ohio Foundation for Medical Care

The minutes of the February 5, 1975 meeting of the Board of Trustees of the Ohio Foundation for Medical Care were presented for the information of the Council by Mr. Gillen.

Committee Reports

Committee on Rehabilitation

The minutes of the Committee on Rehabilitation meeting of February 5, 1975, were presented by Mr. Houser.

The Committee recommended that existing language in the Medical Practice Act which would allow physical therapists to perform "EMG's" be eliminated by the Ohio General Assembly, at the request of OSMA. This was approved.

An offer of assistance to the Ohio Department of Welfare, by the Committee, for the purpose of evaluation of policies on medical equipment, was approved.

The Council also approved suggestions for communication with the Director of Welfare with regard to reconsideration of the Department's policy on "ten day limitation" of visits each month.

A recommendation that it be made possible that each physician receive reimbursement when the patient visits physicians of more than one field of practice on a given day was approved.

The report as a whole was approved.

Ohio Cancer Coordinating Committee, Inc.

The minutes of the February 16, 1975 meeting of the Ohio Cancer Coordinating Committee, Inc., were presented by Mr. Clinger and were accepted for information.

Committee on Eye Care

The minutes of the February 16, 1975 meeting of the Committee on Eye Care were presented by Mr. Rader.

In connection with third party problems involving eye care reimbursements, the Council reaffirmed existing OSMA policy that physicians directly bill their patients.

The concept endorsed by the Committee of establishing qualifications and registering opticians under the Medical Practice Act was approved. (Dr. Gaughan abstained)

The report as a whole was approved.

Committee on Emergency and Disaster Medical Care

The minutes of the February 22, 1975 meet-

ing of the Committee on Emergency and Disaster Medical Care were presented by Mr. Houser. A news release on the tornado season was approved and the report as a whole was accepted.

Committee on Health Manpower

The minutes of the February 21, 1975 meeting of the Committee on Health Manpower were presented by Mr. Clinger.

The Council approved the Committee's suggested revisions of the Health Manpower bill and authorized introduction of the measure in the Ohio General Assembly.

Committee on Mental Health — Subcommittee on Physician Effectiveness

The minutes of the February 23, 1975 meeting of the Subcommittee on Physician Effectiveness of the Committee on Mental Health were presented by Mr. Clinger and were approved.

Joint Advisory Committee on Sports Medicine

The minutes of the February 26, 1975 meeting of the Joint Advisory Committee on Sports Medicine were presented by Mr. Clinger.

The report was approved with the exception of the recommendation on objects in the mouth (except approved mouthpieces) during athletic contests. It was felt that athletes should be made aware of the potential hazards of gum, tobacco, etc., in the mouth during these contests but the Council did not endorse a ruling to prohibit this practice.

Ad Hoc Committee on Redistricting

The minutes of the March 2, 1975 meeting of the Ad Hoc Committee on Redistricting were presented by Dr. McLarnan. The final paragraph of the report was amended to read as follows:

"It is, therefore, the recommendation of the Committee that the Council not introduce a resolution for redistricting."

The report as a whole was approved.

Testimony in connection with the report was presented by Dr. William Dorner, Jr., President, and Dr. Rocco Antenucci, President-Elect, Summit County Medical Society.

Fee Review Committee

The minutes of the March 7, 1975 meeting of the Council Fee Review Committee were presented by Mr. Campbell and were approved.

Councilor Reports

The Councilors reported on activities in their districts.

(Continued on Next Page)

Federal Legislation

Mr. Edgar reported on proposals now in the Congress of the United States.

He reported that the Health Subcommittee of the U.S. House of Representatives Committee on Ways and Means had announced that it would begin writing a national health insurance bill after April 15.

He also reported that a number of professional liability bills had been introduced in The Congress, that the crisis was receiving a considerable amount of Congressional attention, and that a wide variety of solutions was being discussed.

Mr. Edgar also called to the Council's attention a brief analysis of ten bills planned or being considered by the American Medical Association. Analyses of a number of bills of interest to medicine were distributed.

State Legislation

Mr. Rader presented a report on state legislative proposals for Council action, as follows:

H.B. 244, commitment procedures for mentally ill — progress report.

H.B. 257, permits Legislature to invalidate State Board rules — active opposition.

H.B. 275, anti-fluoridation — opposition.

H.B. 328, venereal disease education from grades seven through twelve — approve in principle.

H.B. 432, optometry law changes — opposition.

S.B. 69, exempts some domestic work from workmen's compensation program — support.

S.B. 107, venereal disease education from grades seven through twelve — approve in principle.

S.R. 59, requests Legislative Service Commission study of professional liability situation — for information.

S.J.R. 13, requests Legislative Service Commission study of professional liability situation — for information.

A bill not yet introduced on anti-substitution repeal — active opposition.

The matter of the testimony by the Ohio Osteopathic Association of Physicians and Surgeons on S. 229, to establish an osteopathic school of medicine in Ohio, was discussed in detail by the Council.

A proposal with regard to an effort to fund genetic testing centers in the Ohio budget was referred to the Committee on Laboratory Medicine for study.

Geauga County Resolution

A resolution "for presentation to the Council

of the Ohio State Medical Association" from Geauga County, was presented to the Council.

The Council voted that the resolution be accepted as a resolution to the OSMA House of Delegates, if this is the expressed wish of the Geauga County Medical Society.

Communication from the Drs. Binder

A communication from Dr. Rudolph and Hertha Binder, regarding the American Medical Association, was accepted for information.

Columbiana County Communication

An unsigned communication from the Columbiana County Medical Society was brought before the Council.

The Council replied as follows:

"Your county society's statement of February 18, 1975, was considered and discussed thoroughly by the members of the Council in Session March 8 and 9, 1975, in Columbus.

"It was unanimously determined that there has never been an attempt by the Ohio State Medical Association to exclude Dr. Pichette as your duly elected representative, and that he continues to represent Columbiana County as the Sixth District Councilor.

"Therefore, the Council concluded, without dissent, that the suggestion in the final paragraph of your statement is inappropriate."

Contract Problem

With regard to a request for information on a hospital contract, the Council advised that OSMA policy calls for direct billing of the patient.

The physicians were advised further to bring the matter before the Ohio Radiological Society.

Proposed Analysis of Claims

On behalf of the Cleveland Academy of Medicine, Dr. Gaughan submitted a proposed policy statement on the "Proposed Analyses of Claims."

It was requested that the statement be forwarded to the members of the Council for study and that a vote be taken by mail on approval as the OSMA policy statement on the matter.

Planning Committee

Dr. Henry announced that Drs. Robert N. Smith, William Dorner, Jr., and William C. Earl have been named as a committee to meet with the Ohio Director of Health and the Governor with regard to planning under P.L. 641.

Adjourned.

ATTEST: Hart F. Page
Executive Director

Deadline is May 16 for AMA Annual Meeting Resolutions

Any resolution to be considered by the AMA House of Delegates at the Annual Meeting in Atlantic City on June 15-19 must be introduced by May 16. Emergency resolutions which were not presented to the OSMA House of Delegates will still be considered if they are presented to the AMA House of Delegates by a member of the Ohio Delegation before midnight on that date.

You may submit a resolution to:
P. John Robechek, M.D.
Co-Chairman, Ohio Delegation to the AMA
3461 Warrensville Center Rd.
Cleveland 44122

Oscar W. Clarke, M.D. Vice-Chairman, Ohio Delegation to the AMA Holzer Medical Center Clinic Box 344 Gallipolis 45631.

AMA Files Suit Against HEW

The AMA Board of Trustees filed suit against the Department of Health, Education, and Welfare on February 20, naming Caspar W. Weinberger, HEW secretary as the defendant. The suit is designed to block new utilization review regulations covering Medicare and Medicaid patients, which the HEW issued February 1.

The regulations require hospitals to establish so-called "Utilization Review Committees" by April 1, 1975 to rule on the medical necessity for hospitalization of each Medicare or Medicaid patient within 24 hours of his or her hospital admission.

A group of 15 citizens (5 physicians and 10 patients) has joined the AMA in filing the legal action in the Federal District Court in Chicago. The AMA's suit attacks the legal and constitutional basis of the regulations.

The government contends that the utilization review system would reduce its \$25 billion-a-year bill for care given to 50 million Americans under Medicare and Medicaid (reported by New York Times, February 23, 1975).

Malcolm Todd, President of the AMA, stated, "We believe all such regulations to be wrong legally, wrong medically and wrong morally and we will resist every attempt made to impose them on our patients." Dr. Todd further charged that rather than reducing medical costs, the HEW

regulations would increase the cost of care while reducing the quality, as a result of Federal Reimbursement of Utilization Review Committees physician and non-physician members time-consuming work.

AMA Conference to Discuss Medical Aspects of Sports

To encourage a more humanistic approach to sports for youth, facilite improved physical and mental health for adults through exercise and leisure pursuits, and explore the interactions between mental and physical activity, the AMA will sponsor a Conference on the Mental Health Aspects of Sports, Exercise and Recreation. Held in conjunction with the AMA Annual Convention, the conference will be June 13-14 in Atlantic City. The registration fee is \$40, and \$20 for one-day or student registration. For information, write Committee on the Medical Aspects of Sports, AMA Headquarters, 535 N. Dearborn, Chicago, Ill. 60610.

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Summary of the National Health Planning and Resources Development Act of 1974

EDITOR'S NOTE: Following is a summary of the National Health Planning and Resources Development Act of 1974—Public Law 93-641. The author of the bill, Congressman Paul Rogers (D-Fla.) told the American Medical Association's 1975 Leadership Conference on January 25 that his bill—or law—provides for grass roots control. Congressman Harley Staggers (D-W.Va.) Chairman of the House Interstate and Foreign Commerce Committee, describes the legislation as setting the stage for national health insurance. In any event, the law gives the Secretary of Health, Education and Welfare direct control over local health services and facilities. OSMA members are urged to study this summary and decide for themselves which Congressman is closer to the truth.

The Act contains two new Titles to the Public Health Service Act. Title XV is entitled National Health Planning and Development, composed of four parts, and Title XVI, Health Resources Development, composed of six parts. The law as a whole is referred to as the National Health Planning and Resources Development Act of 1974.

I. NATIONAL HEALTH PLANNING AND DEVELOPMENT

The planning title establishes a mechanism strongly controlled and regulated by the Secretary of Health, Education, and Welfare through a five tier system composed of 1) the Secretary, 2) the National Council on Health Planning and Development, 3) the State Agency, 4) Statewide Health Coordinating. Council, and 5) Health Systems Agency. The law would regulate new health facilities services and would establish up to 6 projects for state rate regulation.

National Guidelines, Priorities, and Health Planning

The law first would require the Secretary of Health, Education, and Welfare (hereafter, Sec-

retary) to issue through regulations national guidelines concerning health planning policy, which may be issued as the Secretary deems necessary. The guidelines would include standards for the "appropriate supply, distribution, and organization of health resources", and a statement of national health planning goals expressed in quantitative terms. The Secretary is to consult with all local and state planning agencies in developing his guidelines. However, Congress has in this Act predetermined certain national health priorities which are deemed to be deserving of priority consideration in national health planning goals and in development of federal, state, and area health planning and resources development programs. These priorities include development of multi-institutional systems for coordination or consolidation of institutional health services, provision of primary care especially to rural and economically depressed areas, development of medical group practices, utilization of physician assistants, development of multi-institutional arrangements for sharing of support services, promotion of facilities to achieve needed improvements in the quality of health services, development by institutions to provide various levels of care on a geographic basis, preventive health care services, uniform cost accounting and development of methods for educating the general public concerning proper personal health care.

The law would also establish a National Council on Health Planning and Development. This Council would be composed of 15 members (3 ex officio, and the balance appointed by the Secretary), of which at least 5 would be consumers, at least 3 would be members of governing bodies of health systems agencies (HSA's), and at least 3 would be members of Statewide Health Coordinating Councils (SHCC's). The Council would be responsible to advise, consult with, and recommend to, the Secretary in his development of national guidelines and in his implementation and administration of this law.

Health Systems Agencies

The Act would provide for establishment of health systems areas throughout the United States. The areas would generally be based on minimum/ maximum population limits with certain exceptions, would be a "geographic region appropriate for the effective planning and development of health services," and would include, if possible, at least one center for the provision of highly specialized health services. The boundaries of the areas would be those established by the Governor of the State, provided that the Governor makes a determination following the criteria established by the Secretary and responding within the time limits effective when the Secretary requests the Governor to submit boundary designations. Should the Governor fail to respond, or should the Secretary determine that the boundaries as proposed do not meet the requirements, the Secretary shall establish the boundaries of the area. The Secretary would be required to review periodically, or upon request, the boundaries of the areas.

For each area an HSA would be established, provided it is capable of performing its function as determined by the Secretary. The HSA would be either a private non-profit corporation or a public body, with an independent governing board composed of a majority (but not greater than 60%) of consumers, and which would have at least 1/3 of its members who are direct providers of health care. An HSA would be required to have a minimum professional staff. The HSA would be responsible for establishing and reviewing annually the health systems plan (HSP) and in establishing an annual implementation plan (AIP), for approving grants to all applicants for funds from the Area Health Services Development Fund, to approve or disapprove applicants for funds under the Public Health Service Act. with certain exceptions, under the Community Mental Health Centers Act, and under the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 and to approve or disapprove, within its area, requests for funds from the State provided to the State as an allotment under the Public Health Services Act. The Secretary would have the authority to reverse an adverse decision. The HSA would also review and recommend to the State the need for proposed new institutional health services, would review all instructional health services at least every 5 years and recommend to the State the appropriations of the services and would annually recommend to the State projects and priorities for modernization, construction, and conversion of medical facilities.

The Secretary would have authority to provide technical assistance to encourage organizations to develop into HSA's. The Secretary would also contract with the HSA on an annual basis to

provide planning grants provided it met criteria as established by the Secretary. Grants would be on a capitation basis but would be renewed only after determination by the Secretary that the HSA had fulfilled its functions in a manner satisfactory to the Secretary.

State Health Planning and Development

The Secretary would be empowered to enter into contracts with the State to perform the health planning functions through a State Agency. However, any State having a contract would have to have an administrative program approved by the Secretary, would establish a Statewide Health Coordinating Council (SHCC) and would not have its agreement renewed by the Secretary if it fails to perform its functions to the satisfaction of the Secretary. In addition, the Secretary would not allot any federal funds under the Public Health Services Act, the Community Mental Health Centers Act or the Comprehensive Alcohol Abuse Act of 1970 for health resources support if an agreement between him and a State was not in effect within the 4th fiscal year after the calendar year of the enactment of this law.

The Secretary could not approve a state administration program unless it met criteria promulgated by the Secretary relating to qualifications of personnel, methods of administration, evaluation standards for performance, and project review standards.

The State Agency would conduct the Health planning activities of the State. It would annually review and revise the HSP's in preparing a preliminary State plan, would assist the SHCC, would serve as the agency for Sec. 1122 review under the Social Security Act, would administer a State certificate of need program applicable to new instutional health services and satisfactory to the Secretary, and make findings as to the need for new institutional health services.

The SHCC would consist of at least 16 members, composed of at least two representatives from each HSA. The Governor would in addition be able to appoint 40% of the total membership of the SHCC. A majority of the members would be consumers; at least ½ could be direct providers. The SHCC would prepare, review, and revise at least annually the State plan composed of the HSP's, would review HSP's, would review the annual budget of each HSA, and would review grant requests made by the HSA and the State.

The Secretary would also be given authority to enter into agreements with not more than 6 State Agencies which wish to carry out rate regulation of the provision of health care. Any State Agency would meet the criteria as established by

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(Continued)

the Secretary, would indicate to the Secretary (no later than 6 months from enactment of this law) its intent to regulate rates and would demonstrate the necessary authority for such regulation under State law.

General Provisions

The law would define "provider of health care" as an individual

"(A) who is a direct provider of health care (including a physician, dentist, nurse, podiatrist, or physician assistant) in that the individual's primary current activity is the provision of health care to individuals or the administration of facilities or institutions (including hospitals, long-term care facilities, and health maintenance organizations) in which such care is provided and, when required by State law, the individual has received professional training in the provision of such care or in such administration and is licensed or certified for such provision or administration; or (B) who is an indirect provider of health care in that the individual—(i) holds a fiduciary position with, or has a fiduciary interest in, any entity described in subclause (II) or (IV) of clause (ii); (ii) receives (either directly or through his spouse) more than one-tenth of his gross annual income from any one or combination of the following: (I) Fees

or other compensation for research into or instruction in the provision of health care. (II) Entities engaged in the provision of health care or in such research or instruction. (III) Producing or supplying drugs or other articles for individuals or entities for use in the provision of or in research into or instruction in the provision of health care. (IV) Entities engaged in producing drugs or such other articles. (iii) is a member of the immediate family of an individual described in subparagraph (A) or in clause (i), (ii), or (iv) of subparagraph (B); or (iv) is engaged in issuing any policy or contract of individual or group health insurance or hospital or medical service benefits."

The law would define health resources as meaning health services, health professions personnel, and health facilities.

Institutional health services would mean health services provided through health care facilities and HMO's as such are defined by the Secretary through regulations promulgated under Sec. 1122 of the Social Security Act and includes the entities through which the services are provided.

The Act also would establish minimum review criteria, to be developed by agencies pursuant to regulations published by the Secretary

The Secretary would also develop planning methodology and technology to assist State and area agencies in their own planning and would

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COLUMBUS: 1989 West 5th Ave., (614) 486-3939, J. E. Hansel TOLEDO: Suite 221, 5241 Southwyck Blvd., (419) 865-5215, R. E. Stallter provide for the setting up of minimum data needed for planning. In particular, the Secretary would establish, within 1 year, a uniform system for calculating cost, a uniform system for cost accounting, a uniform system for calculating rates, and a classification system for health services institutions of costs and rates. The Secretary would also establish up to 5 centers for health planning development.

The Secretary would also review and approve or disapprove annually the budget of each HSA and State Agency, would prescribe performance standards of each, and would review at least every three years the structure, function, performance, plans, personnel, and accomplishments of each.

Health Resources Development

The law would replace the present Hill-Burton Program. The purpose of the law would be to modernize medical facilities, to construct new outpatient medical facilities, to construct new inpatient medical facilities in areas of rapid population growth, and to convert existing medical facilities.

The Secretary would establish regulations prescribing the manner in which the State Agency would determine priority among projects (with emphasis or rural and urban poverty areas, outpatient and preventive care, and densely populated areas), would set criteria for modernization need determination, and would provide adequate medical facility services to everyone in the State and to those unable to pay.

The State plan would be developed through the State Agency and the Statewide Health Coordinating Council, would be approved by the Secretary and would establish priorities among identified needs. An application would be reviewed and approved by the State Agency. The Secretary could reverse an adverse decision toward an applicant.

Amounts available from federal funds would be allocated either directly to the State which would then determine and make project grants, or in the form of loan guarantees allocated in amounts by State. There is provision for the withholding of grant amounts from a State which fails to maintain compliance with its program in the determination of the Secretary.

Not more than 20% annually of the funds may be obligated for new facilities for inpatient treatment in areas of the State experiencing rapid population growth and not less than 25% annually may be obligated for outpatient facilities serving medically underserved populations.

The Act would also establish Area Health Services Development Funds, to be administered by the HSA's to contract with entities to plan and develop projects which the HSA deems necessary for achievement of its HSP. The fund amount could not exceed a per capita determination.

Involuntary Servitude for Doctors?

The Health Manpower Act of 1975 — H.R. 2956 (Rogers, Fla.) has been recommended for passage by the Health Subcommittee of the U.S. House of Representatives' Interstate and Foreign Commerce Committee, in spite of opposition from medicine, including the American Medical Association.

The bill would have mandatory service requirements for students graduating from federally-assisted medical schools. Upon graduation and licensure, a new physician would be required to serve one year in a federally designated area and setting for each year a grant is made to the school. The bill would also create federal control of all residency programs and require establishment of remote-site training facilities.

Medical school assistance would be on a capitation basis, with schools forced to obtain pledges of service from entering students. A student who elected to "buy out" of his mandatory service would have to pay a punitive payback double the amount of the capitation grant.

The bill is not only a form of involuntary servitude for new physicians, but also doubly discriminates against the economically disadvantaged who lack the funds to "buy out" of mandatory service.

Ohio Congressman Samuel L. Devine (R.) and Charles J. Carney (D) are members of the Subcommittee. Congressman Devine is the ranking minority member of the Interstate and Foreign Commerce Committee.

Another health manpower bill, H.R. 3279, also called the "Health Manpower Act of 1975," has been introduced under the auspices of the Association of American Medical Colleges. The bill would, among other items, establish quotas for students from "medically under-served population areas," encourage regionalization of medical and other health training by establishing medical school-affiliated area health education centers; encourage primary care training; and establish a National Health Service Corps. Scholarship recipients would have to agree to serve in areas designated by the Secretary of Health, Education and Welfare. The new physician's period of service would be according to the number of years he or she had accepted academic assistance.

The bill also would invade residency training programs, giving the Secretary of HEW authority to deny federal funds to a program exceeding the number of residencies approved for that program. The Secretary of HEW could designate a "Medical Residency Training Program Accrediting Agency." Programs not approved by the agency would not receive federal funds.

The Professional Liability Crisis

A Special Report From Your President

On February 28, the following letter from James L. Henry, M.D., OSMA President, was sent to all OSMA members. The letter outlines what OSMA is doing to alleviate the current professional liability crisis for Ohio physicians. Dear OSMA Member:

On January 31, 1975, I promised each of you a Special Report within 30 days regarding OSMA's studies, investigation and an action program to assure OSMA members of the professional liability protection so critically necessary to the practice of medicine.

Following are the highlights of accomplishments in the last 30 days, as well as a look into the future regard-

ing remedial action:
On January 30, OSMA officials and many Ohio County Medical Society officials met with the State of Ohio Department of Insurance Director Harry V. Jump and his staff. Mr. Jump and his staff were very receptive to short term and long term remedial action programs suggested by organized medicine. It is very important to note that Mr. Jump asked that all remedial efforts be coordinated through the Department of Insurance. Mr. Jump promised his personal leadership in coordinating the efforts of the Ohio Depart-ment of Insurance, Ohio State Medical Associa-tion, Ohio Osteopathic Association, Ohio Hospital Association, Ohio State Bar Association and the insurance carriers.

On January 31, the OSMA President, President-Elect and Executive Director met with their counterparts representing the Ohio State Bar Association. The meeting was highlighted by a genuine expression of concern and the absolute necessity to solve this critical problem that has serious medical, social, public relations, and eco-nomic ramifications. Officers of both Associations will meet again on March 7 and each month

thereafter if the situation so indicates.

 On February 1, the OSMA Council approved a recommendation from the OSMA Committee on Insurance that the Johnson & Higgins Company be authorized to conduct a feasibility study with regard to the advisability of a sponsored professional liability insurance plan in Ohio.

On February 1, the OSMA Council adopted the

following short and long range programs to deal

with professional liability problems.

Short Range Program

1. The OSMA program which assists in obtaining professional liability coverage for physicians who have lost their insurance and which assists in obtaining coverage for new physicians entering in practice in Ohio is to be energetically con-

2. Officers and staff of the Association were asked to continue to work closely with the Ohio Department of Insurance in problem-solving operations in the areas of cost and availability of

professional liability insurance.

3. The officers and the staff were instructed to continue their work with the officers and staff of the Ohio State Bar Association in working out

solutions to the professional liability crisis.
4. The officers and staff were directed to continue their work with the officers and staff of the Ohio Hospital Association and the Ohio Osteopathic Association of Physicians and Surgeons and related groups in a mutual effort to solve mutual concerns in professional liability.

The officers and staff were directed to make a formal approach to the medical specialty societies in Ohio offering assistance and asking for a unified program on professional liability.

Long Range Program

1. The Association will cooperate with the Ohio Department of Insurance in a "six group consortium." (Ohio State Medical Association, Ohio State Bar Association, Ohio Osteopathic Association, Ohio Hospital Association, Ohio Department of Insurance, and professional liability insurance carriers.)

2. Legislative programs will be initiated in coopera-

tion with the consortium.

3. OSMA legislative priorities were established as follows:

Commission plan. (a) (b) Binding arbitration.

Informed consent forms.

(d) Amendment of Statue of Frauds (oral prognosis not admissible in court).

4. In light of the feasibility study approved above, the Council voted not to be involved with establishing its own professional liability company at this time.

• On February 4, every Specialty Society in the state of Ohio was invited to coordinate its re-

medial efforts with and through OSMA.

On February 5, OSMA informed the public through a press release, of the critical nature of the professional liability crisis and the efforts being made to reach a reasonable lasting solution.

On February 11, OSMA obtained individual written statements of sincere concern and support

from the leadership of both political parties of the Ohio Senate and The Ohio House of Representatives. Governor James A. Rhodes has expressed concern about the professional liability crisis and is aware of the need for lasting solu-

On February 12, OSMA was informed by the Ohio Department of Insurance that several major professional liability insurance carriers had met with the Ohio Department of Insurance and

agreed on a short term basis:

To renew all current risks unless overriding individual underwriting considerations prevent such

renewals.

To insure new, young physicians who are joining a "group" currently insured by the company. It should be understood that the cooperative agreements outlined above are short term and will provide an opportunity for the six member consortium to enact a remedial, unified pro-

 Harry V. Jump, Director, Ohio Department of Insurance has announced a meeting to consider all aspects of a remedial, unified program, basically legislative. OSMA will be one of the primary contributors in this effort, OSMA is considering,

in addition to the legislative program outlined above in this letter, the following proposals:

1. Placing a ceiling on damages.

2. Eliminating the addendum clause in law

3. Counter claim for abuse of process.

4. Exclude duplication of payments made to claimants.

Your support of remedial legislation by contacting your local state legislators will be solicited in future issues of the OSMAgram and The Ohio State Medical

Journal.

I would like to conclude this Special Report by assuring each of you of our continued highest priority involvement in solving this most serious problem and to thank each of you who took the time to communicate with me regarding this subject.

James L. Henry, M.D. President

Teledyne Inc. has announced that it plans for Argonaut Insurance Co., its subsidiary, to discontinue writing professional liability protection policies for individual physicians this year. The Wall Street Journal (Feb. 19, 1975) reports that such a move "could be staggering since at year-end, according to a spokesman, Teledyne insured some 30,000 physicians for malpractice coverage and was one of the very few large com-

panies left in the field.

It was reported that the company will continue to provide malpractice insurance for hospitals, although at higher rates and covering fewer risks. Approximately 25 percent of the nation's hospitals are covered by Argonaut. The company has informed hospitals in a number of states that it will not renew their policies, according to the American Hospital Association.



A Legal Opinion

Physicians Transferring Assets In Light of Malpractice Threat

As one response to the professional liability crisis, some physicians are considering transferring all of their assets to their wives or trusts, then cancelling or failing to renew their professional liability insurance. The OSMA staff has asked its legal counsel, James E. Pohlman, Esq., to consider the broad implications of collecting a judgment against a physician who has transferred his assets and no longer carries protective insurance. The following paragraphs express Mr. Pohlman's legal evaluation and opinion.

The first problem with this technique is that such a transfer could possibly be set aside as a fraudulent conveyance. A fraudulent conveyance will be presumed by the law under a variety of situations. One factor in particular that almost always raises such a presumption is a transfer made without consideration, e.g. a transfer of assets by a husband to his wife without any corresponding monetary consideration.

Another factor in questioning whether a transfer might be fraudulent is a voluntary conveyance made by a debtor in anticipation of a suit against him or in apprehension of future litigation. A final factor raising the specter of fraudulent conveyance is whether a transfer or conveyance includes all of an individual's property.

Some familiar fraudulent devices used are secret trusts or unrecorded deeds. All of these devices are especially suspect where they are transacted between close relatives.

Assuming that the transfer was somehow held to be legitimate and not set aside, a plaintiff's counsel might still attempt to satisfy any judgment rendered in a medical malpractice case out of the physician's current income. The plaintiff's counsel would subpoena the physician into court for a judgment debtors exam (penalty for failure to show is a contempt citation). The physician would be required to bring a list of all his accounts receivable. The court would then notify each debtor to pay the judgment creditor rather than the physician. (This is called a creditors bill.) Other means of collection would be attachment of bank accounts and garnishment of any salary, in the case of professional corporations.

In short, the proposed technique of transferring assets to a family member would not, in Mr. Pohlman's opinion, render a physician "judgment proof" in a medical malpractice case.

Ohio Department of Health

JOHN H. ACKERMAN, M.D., Director

Chemoprophylaxis for Contacts of Meningococcal Disease

There have been five reports in recent medical literature of an unusually high incidence of vestibular reactions associated with the use of minocycline for chemoprophylaxis of contacts of meningococcal disease. The symptom complex consists of dizziness, vertigo, ataxia, nausea, and vomiting. The onset is generally within the first 48 hours of therapy, and subsides within 48 hours of discontinuing therapy. Substantial numbers of patients in several of these reports have spontaneously discontinued therapy before the recommended course was completed.

Because of the reported adverse effects and their potential dangers, as well as the high incidence of spontaneous discontinuation of the treatment regimen, the Center for Disease Control has recommended the use of alternative drugs. Unless an epidemic strain of Neisseria Meningitidis is known to be sulfa-sensitive, the Center for Disease Control recommends the use of rifampin for close contacts of cases of meningococcal disease. The recommended dose for adults is 600 mg. twice a day for two days. The dosage for children age 5-12 is 10 mg. per kilogram twice a day for two days. At present, rifampin is not approved by the Food and Drug Administration for children under the age of 5 years, although this approval is expected in the near future. It is recommended for children less than 5 years old who have had close contact with a case of meningococcal disease that they be kept under very close surveillance if not given chemoprophylaxis. Despite the lack of F.D.A. approval, the Center for Disease Control recommends treating close contacts less than 5 years old with rifampin in the following dosage: 10 mg. per kilogram twice a day for two days for children age 1-5; 5 mg. per kilogram for two days for infants age 3 months to 1 year.

The Care of Biologicals

Constant caution is necessary to maintain the potency of biologicals. Personnel who handle biologicals should observe the following guidelines in immunization procedures in order to make certain that patients get effective vaccines.

RULES

1) Never store vaccines on refrigerator door because of lowered temperature. 2) Use styrofoam container to transport biologicals: Add ice packs to protect vaccine. Use dry ice for polio only.

POLIO:

When maintained continuously in the frozen state at 14°F or lower, the vaccine will retain its potency for 12 months as indicated by the expiration date.

UNOPENED polio vaccine may be refrozen if it thaws in storage or transit provided the temperature does not exceed 46°F during the thaw period. A maximum of 10 freeze/thaw cycles is permissible for UNOPENED vaccine provided the cumulative duration of thaw does not exceed 24 hours and temperature never goes over 46°F. UNOPENED vials of vaccine in the liquid state may be used up to 30 days provided they have been stored at 35°-46° during that period.

Once opened, polio vaccine must be kept refrigerated between doses and used within 7 days. If vaccine is NOT returned to refrigerator between doses, it must be thrown out at the end of the day.

DO NOT REFREEZE polio vaccine after opening.

Polio vaccine has a variable red to yellow tinge. Color changes may occur on thawing or storage but are unimportant if vaccine remains crystal clear. (However, the possibility of bacterial contamination should be considered whenever a thawed and entered vial shows color changes from red to pink to yellow during subsequent storage.)

MEASLES, RUBELLA, MUMPS:

These vaccines are extremely light and heat sensitive.

Exposure of these vaccines to light — either before or after reconstitution — KILLS THE LIVE VIRUS.

Store in refrigerator at 35.6°-46.4°. PROTECT FROM LIGHT. Use only the diluent supplied to reconstitute the vaccine. After mixing, use vaccine as soon as possible.

Store reconstituted vaccine in a dark place (in its carton, within a towel or wrapped with aluminum foil) and in the refrigerator. Discard mixed vaccine if not used within 8 hours.

DPT (Diphtheria, Tetanus, Pertussis), TD (Tetanus, Diphtheria):

Store at 35°-46°F.

DO NOT FREEZE — this reduces potency. Shake vial vigorously before withdrawing each dose.

OSMA Annual Meeting

12 Special Continuing Medical Education Courses

Tuesday and Wednesday May 13 and May 14

Special Note:

This continuing medical education activity is currently acceptable for credit in Category 2 on an hour for hour basis toward the AMA Physicians Recognition Award. We expect to have a survey arranged by the AMA Council on Medical Education during our scientific sessions on May 13. If the Council, following a review of the team report, accredits OSMA for its continuing medical education program, we will notify you, or announce it in our bulletin.

Following accreditation by AMA Council of the OSMA continuing medical education activities, you could claim Category 1 credit on an hour for hour basis, retroactively to the sessions to be held in May,

1975.

Index of Courses

Course One Clinical Management of Electrolyte and Acid Base Disturbances

Course Two Principles of Electrocardiography

Course Three Chemotherapy of Infections

Course Four Vascular Diseases

Course Five Ischemic Heart Disease
Course Six Immunology Principles

Course Seven Cancer: Current Concepts in Treatment

Course Eight Endocrine Emergencies

Course Nine Introduction to Sexual Counseling

Course Ten Business Management in a Doctor's Office

Course Eleven Chronic Obstructive Lung Diseases

Course Twelve Emergency Cardiac Care

Basic Life Support (Cardio Pulmonary Resuscitation)

Course One

Clinical Management of Electrolyte and Acid

Base Disturbances
Venus Room
Shoreton Columbus

Sheraton-Columbus 7:30-9:00 a.m.

Fee: \$15.00

Tuesday, May 13

Course Director: William H. Bay, M.D., Fellow in Nephrology, Division of Renal Disease, Ohio State University

Onio State University

Blood Gases—
This course will develop a method of classification of blood gases into four areas; respiratory acidosis, respiratory alkalosis, metabolic acidosis, and metabolic alkalosis. The pathophysiology and compensatory mechanisms will be stressed. Appropriate case studies will be used to conclude this course.

Wednesday, May 14

Course Director: Richard H. Mauk, M.D., Fellow in Nephrology, Division of Renal Disease, Ohio State University

Fluid and Electrolyte Problems and Clinical Management

This course will present case studies discussing commonly encountered abnormalities of fluid and electrolyte metabolism. The cases will consider alterations in plasma sodium concentration and its meaning in various clinical settings. Acid base balance will be only briefly discussed in relation to alteration in potassium and sodium metabolism, as acid base will be the subject of a subsequent discussion. The general topics to be covered are listed as follows: Hyponatremia (in edematous states; in non-edematous states); Hypokalemia and metabolic alkalosis.

(Continued)

(Continued)

Course Two

Principles of Electrocardiography China-Malay Room Sheraton-Columbus 7:30-9:00 a.m.

Fee: \$15.00

Tuesday, May 13 and Wednesday, May 14 Course Director: Stephen F. Schaal, M.D., Assistant Professor of Medicine, Division of Cardiology, Ohio State University Hospitals

This course will be an introduction to the principles of electrocardiography with analysis of electrophysiologic principles in the clinical assessment of conduction defects and arrhythmias. The electrocardiographic recognition of myocardial ischemia and infarction, bundle branch block and hemiblocks, hypertrophy of atria and ventricules, and brady and tachyarrhythmia will be discussed.

Course Three

Chemotherapy of Infections
Baltic-North Room
Sheraton-Columbus
7:30-9:00 a.m.

Fee: \$15.00

Tuesday, May 13 and Wednesday, May 14 Course Director: Robert J. Fass, M.D., Assistant Professor of Medicine (Infectious Diseases) and Medical Microbiology, Ohio State University College of Medicine

The aim of this course will be to bring practicing physicians up to date with new advances in the field of chemotherapy of infections and to place new chemotherapeutic agents in their proper perspective.

Course Four

Vascular Diseases Auditorium Sheraton-Columbus 7:30-9:00 a.m. Fee: \$15.00

Tuesday, May 13 and Wednesday, May 14 Course Director: James Kilman, M.D., Professor of Surgery, Division of Thoracic and Cardiovascular Surgery, University Hospital, Columbus

The course of Vascular Diseases is aimed at acquainting the practitioner with the newest and latest developments in the treatment of cardiovascular and peripheral vascular disease. The latest developments in the diagnostic evaluation and management of the patient with peripheral vascular disease will be presented on the first day of the course with emphasis on the latest development in the management of each specific disease entity and an overall review of the history of vascular prostheses by Dr. William Blakemore who was the first man to use a prosthetic device for the replacement of a blood vessel. The second day will consist of a review of the traditional and newer approaches to the diagnostic workup and management of the patient with cardiovascular disease, especially coronary artery disease and diseases of the great vessels. Each part of the program is to be presented by an expert in the field and an opportunity for discussion with these experts will be present.

Course Five

Ischemic Heart Disease

Taft Room

Sheraton-Columbus

7:30-9:00 a.m. Fee: \$15.00

Tuesday, May 13 and Wednesday, May 14 Course Director: Richard P. Lewis, M.D., Ohio

State University, Columbus Coronary Artery Disease

The laboratory diagnosis of ischemic heart disease will be discussed including the role and indications for coronary arteriography, myocardial contraction pattern analysis and perfusion scanning. New aspects of medical treatment of angina will be presented followed by a discussion of surgical treatment of coronary diseases with saphenous vein bypass.

New Non-Invasive Techniques

The clinical usefulness of the three current premier non-invasive techniques for evaluation of cardiac disease will be discussed. The usefulness and limitations of each as well as the combined use of these tests will be stressed.

Course Six

Immunology Principles Caribbean-Mediterranean Rooms Sheraton-Columbus

Fee: \$15.00

Tuesday, May 13 and Wednesday, May 14 Course Directors: Paul E. Hurtubise, Ph.D., De-

partment of Pathology, Ohio State University College of Medicine.

James A. Neidhart, M.D., Department of Medicine, Ohio State University College of Medicine.

The aims of this course are to provide a basic review of the current concepts of the cellular and humoral immune systems. Deficiencies and malignancies of the immune system components will be discussed. There will also be a description of the use of serum protein electrophoresis and immunoelectrophoresis as a diagnostic tool. The overall objective of this course is intended to provide an outline for the understanding of the management of patients with diseases involving immune system components.

Course Seven

Cancer: Current Concepts in Treatment

Room 208

Veterans Memorial 10:00-11:30 a.m.

Fee: \$15.00

Tuesday, May 13 and Wednesday, May 14

Course Directors: Albert Lobulio, M.D., Professor of Medicine, Department of Medicine, Division of Hematology Ohio State University; and Professor of Oncology, American Cancer Society

Earl N. Metz, M.D., Professor of Medicine, Department of Medicine, Division of Hematology, Ohio State University

The purposes of this course is to acquaint the physician with new concepts in the staging and treatment of malignant lymphoma. This will include evaluation of

parameters which contribute to prognosis and therapy decision making. Recent observations in the treatment of two solid tumors (sarcoma and carcinoma) will be reviewed and discussed. This will include evaluation of recent studies of adjuvant therapy to surgical treatment, as well as therapy of metastatic disease.

Course Eight

Endocrine Emergencies Room 209 Veterans Memorial 10:00-11:30 a.m.

Fee: \$15.00

Tuesday, May 13 and Wednesday, May 14

Course Director: William L. Hall, M.D., President Ohio Chapter, American College of Emergency Physicians; and Chairman, OSMA Section on Emergency Medicine, Columbus

The course is being designed to instruct the physician in the rapid recognition and treatment of severe hyperthyroidism and thyroid storm, myxedema coma, diabetic ketoacidosis, lactic acidosis, hyperosmolar coma, acute adrenal insufficiency, and other associated endocrine emergencies.

Course Nine

Introduction to Sexual Counseling

VM 22

Veterans Memorial 10:00-11:30 a.m.

Fee: \$15.00

Tuesday, May 13 and Wednesday, May 14

Course Directors: Walter Knopp, M.D., Psychiatrist, Department of Psychiatry, Ohio State University

Malcolm Gardner, Ph. D., Psychologist, Department of Psychiatry, Ohio State University

The course will explore the choices the physician has in determining his role in counseling patients with sexual responsitivity and dysfunction. An overview of recent knowledge in human sexual responsitivity and dysfunction, as well as the basic concepts and techniques of treatment and counseling will be presented, illustrated by slides, films, video tapes, and handouts. Implications for some participants's cases will be discussed in the question and answer periods.

Course Ten

Business Management in a Doctor's Office

Room 102

Veterans Memorial 10:00-11:30 a.m.

Fee: \$15.00

Tuesday, May 13 and Wednesday, May 14

Course Director: Robert L. Rothring, C.P.A.
President, Professional Management Service,
Cincinnati

The program is designed to cover office procedures, patient and third party billing, expense control, medical and business records, insurance claims, appointments and general office routine. The second day of the course will be more financially oriented with discussion of the new pension reform act; increased Keogh limitations; incorporating vs. non-incorporating; tax shelters and similar items as time permits.

Course Eleven

Chronic Obstructive Lung Diseases

Rooms 206-207 Veterans Memorial 10:00-11:30 a.m.

Fee: \$15.00

Tuesday, May 13 and Wednesday, May 14 Course Director: Roy Donnerberg, M.D., Asso-

ciate Professor, Ohio State University

Chronic Obstructive Lung Diseases are a leading cause of disability in middle aged men today. The incidence of these diseases is increasing rapidly. Every physician needs to be concerned with the care of these patients. This necessitates a review of respiratory physiology and pathophysiology. This continuing medical education course will serve to review these basic aspects of respiratory physiology and emphasis will be placed on correlating these basic aspects with the diagnosis and therapy of COPD patients in office and hospital care.

Course Twelve

Emergency Cardiac Care

Basic Life Support (Cardio Pulmonary Resuscitation)

South Terrace Exhibit Floor

and

Demonstration Area Veterans Memorial

Time: May 13 9:00 a.m. - 12:00 noon

1:00 p.m. - 4:00 p.m.

May 14 9:00 a.m. - 12:00 noon

for wives of physicians

Fee: No Charge (Must pre-register)

Course Director: Bernard C. DeLeo, M.D.,
American Heart Association National Affiliate Faculty Instructor. All assisting instructors
will be American Heart Association Certified
Instructors.

Instructors and equipment supplied by
The American Heart Association
OHIO AFFILIATE:
Central Ohio Heart Chapter
Akron District Chapter:

Course will involve training according to the National Standards of Basic Life Support (CPR) as published in the supplement of the JAMA, February, 1974. Class participants will be taught and certified in performance skills of cardio pulmonary resuscitation following performance and cognitive testing. Course participants must be able to perform CPR on recording mannikins. Individual team, and infant procedures will be taught.

In simulation of real-life situations, practice will be

done on the floor.

REGISTRATION FORM FOR ALL COURSES IS ON FOLLOWING PAGE.

REGISTRATION FORM CONTINUING MEDICAL EDUCATION **COURSES**

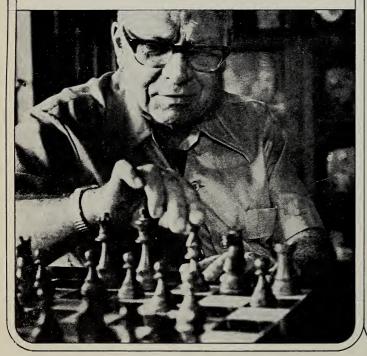
Registration Fee: \$15.00 per course (Courses One through Eleven) No charge for (Course Twelve) but must preregister Courses will be scheduled on Tuesday, May 13 and continued on Wednesday, May 14 at specified times and places. Please register me for Course No. _____ (All courses limited to 35 enrollment) Name_ Address___

Make checks payable to OSMA and return to: Ohio State Medical Association 600 South High Street Columbus, Ohio 43215

(Registration fee includes continental breakfast)

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SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid.
As a secondary reaction some will complain of nausea, sweating and abdominal cramps. The reaction is usually transient.
INDICATIONS: As a cerebral stimulant and vasodilator.
RECOMMENDED GERIATIC DOSAGE: One capsule three times daily adjusted to the individual patient.
WARNING: Overdosage may cause muscle tremor and convulsions.

vulsions.
CONTRAINDICATIONS: Epilepsy or low convulsive threshold.
CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

Write for literature and samples . . .

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Additional

Scientific Programs During OSMA's 1975 Annual Meeting

The following is a continuation of the list of 1975 Scientific Programs printed in The Journal's March issue. All Annual Meeting Scientific Programs have been covered either last month or in the following list. Please refer to the official program you will receive at the Annual

Meeting to check times and places.

The Cardio Pulmonary Resuscitation Course, among twelve continuing medical education courses offered this year, is one in which wives can and should participate. Everyone should be able to perform this technique. There is no charge for the course—just preregister with the form on page 252. Instructors and equipment will be supplied by the American Heart Association; Ohio Affiliate; Central Ohio Heart Chapter and the Akron District Chapter. The course will involve training according to the National Standards of Basic Life Support (CPR) as published in the JAMA supplement, February, 1974. Physicians are asked to register at 9 a.m. and 1 p.m. on Tuesday, May 13. Wives are asked to register for Wednesday's course at 9 a.m. The course will be conducted both days on the Ground Floor of Veterans Memorial Building, adjacent to the exhibit area.

MONDAY, MAY 12 COLON AND RECTAL SURGERY

Program sponsored by the Ohio State Medical Association scientific section on Colon and Rectal Surgery.

11:30 a.m. Luncheon (China-Malay Rooms, Second Floor, Sheraton-Columbus Hotel)

1:30 p.m. Scientific Program (Rooms 206-207, Veterans Memorial Bldg.)

PROGRAM

Chairman: Burchard E. Winne, M.D., Toledo

Program Chairman: A Gerson Carmel, M.D., Fairfield

1:30 p.m. Pilonidal Cyst — Ralph B. Samson, M.D., Columbus, Chairman, Dept. of Surgery, Grant Hospital; Discussion

2:15 p.m. Colonoscopy — Howard J. Eddy, Jr., M.D., Garden City, N.Y.

Panel on Colonoscopy

Moderator, Burchard E. Winne, M.D., Toledo

Howard J. Eddy, Jr., M.D., Garden City, N.Y.

Armin V. Banez, M.D., Youngstown Jack D. Selzer, M.D., Cincinnati

3:15 p.m. Hemorrhoids — To Cut or to Freeze — Armin V. Banez, M.D., Youngstown Discussion to be opened by Edwin B. Hamilton, M.D., Columbus Open Discussion

TUESDAY, MAY 13 NEUROLOGICAL SURGERY

8:30 A.M. (All Day)

Program sponsored by the Section on Neurosurgery and the Ohio State Neurosurgical Society.

MORNING SESSION

Upham Hall Auditorium, University Hospital

8:30 a.m. Breakfast, Room 191, University Hospital Ohio State University Medical Center

9:00 a.m. Introduction and Welcome — Upham Hall Auditorium

Larry Carey, M.D., Chairman, Dept. of Surgery, Ohio State University Medical Center

9:30 a.m. Brain Tumor Chemotherapy; an Update — Neurosurgical Staff, Ohio State University Medical Center

10:00 a.m. Brain Death Criteria for the Neurosurgeon — Transplant and Neurosurgical Staff, Ohio State University Medical Center

10:30 a.m. Neurosurgical Malpractice Insurance Nationally and Locally — William E. Hunt, M.D., Chairman, Department of Neurosurgery, Ohio State University Medical Center

11:00 a.m. Criteria for Aneurysm Surgery — Neurosurgical Staff, Ohio State University Medical Center

11:30 a.m. Newer Concepts in Pediatric Neurosurgery — Neurosurgical Staff, Ohio State University Medical Center

12:30 p.m. Luncheon (Mediterranean-Caribbean Room, Second Floor, Sheraton-Columbus Hotel)

AFTERNOON SESSION

Venus Room, Second Floor, Sheraton-Columbus Hotel

Presiding: Bert H. McBride, M.D., Cincinnati, President, Ohio State Neurosurgical Society

(Continued)

- 1:30 p.m. Unsuccessful Stereotaxic Ablation of a Third Ventricle Colloid Cyst — Yoshiro Takaoka, M.D., Ph.D., and Robert J. White, M.D., Cleveland Metropolitan Hospital
- 1:45 p.m. Major Medical Complications Associated with Severe Cervical Cord Injuries Benedict Colombi, M.D., Cleveland Hgts.; Clinton Miller, M.D., University Hospitals, Cleveland; Yoshiro Takaoka, M.D., Ph.D, and Robert J. White, Cleveland Metropolitan Hospital
- 2:00 p.m. Aneurysmal Bone Cysts of the Spine — Gustavo Berti, M.D., Cleveland Clinic; Donald Dohn, M.D., Cleveland, and Lawrence McCormack, M.D., Cleveland
- 2:15 p.m. Experimental Carotid Basilar Anastomosis Michael Feely, M.D., Cleveland Clinic
- 2:30 p.m. Acute Ascending Encephalomyelitis Stewart B. Dunsker, M.D., Cincinnati; Isao Yamamoto, M.D., Cincinnati; and Frank H. Mayfield, Cincinnati
- 2:45 p.m. Spontaneous Dissecting Aneurysms of the Carotoid Artery — A. Lee Greiner, M.D.,

- Cincinnati; John M. Tew, Jr., M.D., Cincinnati and Stewart B. Dunsker, M.D., Cincinnati
- 3:00 p.m. Surgical Treatment of Arteriovenous Malformations — Set Shahbabian, M.D., Cincinnati; Frank H. Mayfield, M.D., Cincinnati and John M. Tew, Jr., M.D., Cincinnati
- 4:00 p.m. Intermission
- 5:00 p.m. Business Meeting
- 6:00 p.m. Adjourn
- 7:00 p.m. Cocktails and Dinner at the Casa di Pasta, 2321 North High Street (entertainment by the Opera Singers)

INTERNAL MEDICINE

VM 22, Veterans Memorial

Program sponsored by the Ohio Society of Internal Medicine and the Section on Internal Medicine.

Symposium on Practice Efficiency

Moderator: Richard R. Ruppert, M.D., Columbus

Part 1—1:30 p.m.

Communication with patients/ASIM brochures and diagnostic forms/screening history forms/

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Each blue tablet contains:
Nicotinic Acid100 mg.
Niacinamide 75 mg.
Ascorbic Acid
Thiamine HCL (B-1) 25 mg
Riboflavin (B-2) 2 mg
Pyridoxine HCL (B-6) 10 mg. DOSE: 1 to 5 tablets daily.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500,
1000

LIPO-NICIN/250 mg. Each yellow tablet contain	ins:
Nicotinic Acid	.250 mg.
Niacinamide	. 75 mg.
Ascorbic Acid	.150 mg.
Thiamine HCL (B-1)	. 25 mg.
Riboflavin (B-2)	. 2 mg.
Pyridoxine HCL (B-6)	. 10 mg.
DOSE: 1 to 3 tablets da	ily.
AVAILABLE: Bottles of	100. 500.
1000	

GRADUAL RELEASE

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Each timed-release ca	psule con-
tains:	
Nicotinic Acid	300 mg.
Ascorbic Acid	150 mg.
Thiamine HCL (B-1)	25 mg.
Riboflavin (B-2)	2 mg.
Pyridoxine HCL (B-6) .	10 mg.
DOSE: 1 to 3 tablets d	
AVAILABLE: Bottles of	100, 500,
1000	

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient. Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur. Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

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patient education systems/office decor/scheduling/messages and phone calls/dictating systems/ medical records/polyscript/and accounting sys-

2:15 p.m. Audience participation

2:30 - 3:00 p.m. Break for exhibits

Part 2-3:00 p.m.

Moderator: James F. King, M.D., Canton Medical Assistants and Coordinators/filing systems/Special forms/Universal Claim form/computer billing.

3:45 - 4:00 p.m. Audience participation

OCCUPATIONAL MEDICINE 1:30 P.M.

Room 209, Veterans Memorial

Program sponsored by the OSMA Section on Occupational Medicine and the Western Ohio Industrial Medical Association.

PROGRAM

Presiding: R. J. Freedy, M.D., Chairman Section on Occupational Medicine

WHAT YOU BREATHE IS WHAT YOU GET

Speaker: Joseph F. Tomashefski, M.D., Head of the Pulmonary Disease Department of the Cleveland Clinic shall stress some of the newer concepts of etiology, diagnosis and management of occupational lung diseases with case presentations.

PSYCHIATRY

Tuesday, May 13

5:00 p.m. Taft Room, Third Floor, Sheraton-Columbus — Ohio Psychiatric Association Education and Research Foundation

6:00 p.m. Mediterranean-Caribbean Room, Second Floor, Sheraton-Columbus - Ohio Psychiatric Association Council Dinner

7:00 p.m. Taft Room, Third Floor, Sheraton-

Columbus — Ohio Psychiatric Association Council Meeting

WEDNESDAY, MAY 14 **PSYCHIATRY**

MORNING PROGRAM

9:00 a.m. Grant Room, Third Floor, Sheraton-Columbus — Ohio Psychiatric Association Annual Scientific Education and Business Meeting

AFTERNOON PROGRAM RECOGNIZING THE SUICIDAL PATIENT

1:30 p.m. Assembly Hall, First Floor, Veterans Memorial

Presiding: Douglas Lenkoski, M.D., President, Ohio Psychiatric Association, Cleveland

Speaker: George Murphy, M.D., Professor, Chairman, Department of Psychiatry, Washington University, St. Louis, Missouri

EMERGENCY MEDICINE

1:30 P.M.

Room 201, Veterans Memorial

Program sponsored by the Ohio State Medical Association Section on Emergency Medicine.

PROGRAM

Presiding: William L. Hall, M.D., Columbus, Chairman, Section on Emergency Medicine

Law and the Emergency Department -W. Thomas Washam, M.D., Chillicothe

Malpractice Insurance Representative (to be announced)

Panel Program

Moderator: George Millay, M.D., Columbus "The Multiple Injured Patient"

Panelists: Francis Grecius, M.D., Cleveland; Donald Morath, M.D., Cincinnati; and representatives of other local emergency rooms.

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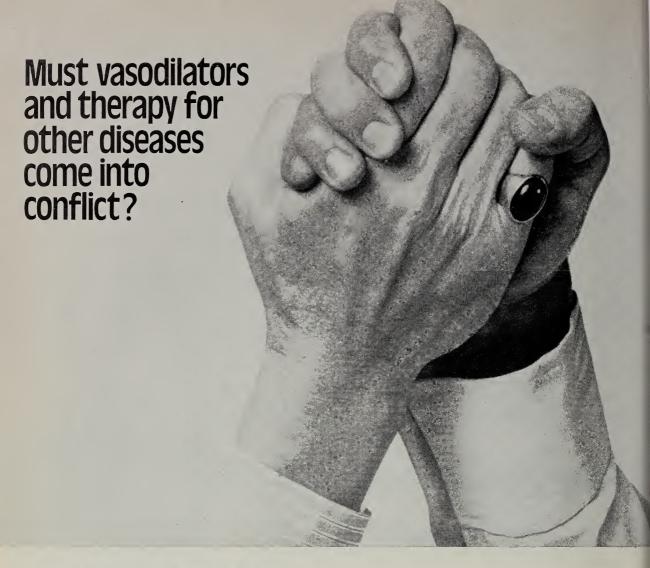
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Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

- 1. For the relief of symptoms associated with cerebral vascular insufficiency.
- 2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
- 3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCI, 10 mg. and 20 mg. Dosage and Administration: 10 to 20 mg. three or four times daily. Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

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Resolutions Submitted for Consideration At the 1975 Annual Meeting

IN THE FOLLOWING COLUMNS are texts Tof several resolutions and titles of others scheduled to be presented for consideration by the House of Delegates at the 1975 Annual Meeting of the Ohio State Medical Association, May 11-14, in Columbus. These resolutions were received in the Columbus Office on or before March 12, thereby meeting the 60-day deadline.

No resolution may be presented or introduced at any meeting of the House of Delegates unless the foregoing requirements for filing and transmittal shall have been complied with or unless such compliance shall have been waived by a Special Committee on Emergency Resolutions named to decide whether late submissions were justified. Please refer to Chapter 4, Section 8 of the OSMA Bylaws entitled, Resolutions for complete clarification.

Copies of all resolutions presented to the Columbus office are being sent to the individual delegates, alternate delegates and presidents and secretaries so that they may be discussed prior to

the Annual Meeting.

RESOLUTION NO. 1-75
Professional Liability
(By the Academy of Medicine of Columbus and Franklin County)

RESOLUTION NO. 2-75
Professional Liability
(By the Academy of Medicine of Cleveland and Cuyahoga County)

RESOLUTION NO. 3-75 Medical Malpractice Insurance
(By the Holmes County Medical Society)

RESOLUTION NO. 4-75 Formation of a Professional Liabilities Review Commission for the State of Ohio (By Alford C. Diller, M.D., Delegate, Van Wert County Medical Society)

RESOLUTION NO. 5-75 Norms or Criteria of Medical Care (By the Academy of Medicine of Cleveland and Cuyahoga County)

RESOLUTION NO. 6-75
HEW Regulations in Regard to Utilization Review
Under the Social Security Act
(By the Academy of Medicine of Cleveland and Cuyahoga County)

RESOLUTION NO. 7-75 Employ Non-Staff Physicians to do PSRO Utilization Review, Certification and Review (By the Academy of Medicine of Cleveland and Cuyahoga County)

RESOLUTION NO. 8-75
PSRO Information and Confidentiality (a)
(By the Academy of Medicine of Toledo and Lucas County)

RESOLUTION NO. 9-75 PSRO Information and Confidentiality (b) (By the Academy of Medicine of Toledo and Lucas County)

RESOLUTION NO. 10-75
PSRO Information and Confidentiality (c)
(By the Academy of Medicine of Toledo and Lucas County)

RESOLUTION NO. 11-75
PSRO Information and Confidentiality (d) (By the Academy of Medicine of Toledo and Lucas County)

RESOLUTION NO. 12-75
PSRO Information and Confidentiality (e)
(By the Academy of Medicine of Toledo and Lucas County)

RESOLUTION NO. 13-75 PSRO Information and Confidentiality (f) (By the Academy of Medicine of Toledo and Lucas County)

RESOLUTION NO. 14-75 Exploitation of Physicians (By the Ross County Medical Society)

RESOLUTION NO. 15-75 OSMA Council Action on PSRO (By the Huron County Medical Society)

RESOLUTION NO. 16-75 To Let Hospitals Implement PSRO (By the Huron County Medical Society)

RESOLUTION NO. 17-75 OSMA Position on PSRO (By the Council of the Ohio State Medical Association)

RESOLUTION NO. 18-75
Confidentiality
(By C. G. Madsen, Jr., M D., Member, Lake County
Medical Society)

RESOLUTION NO. 19-75 Region Six Peer Review Corporation of Akron (By the Council of the Mahoning County Medical Society)

RESOLUTION NO. 20-75
Reaffirmation of OSMA Position on PSRO
(By the Council of the Mahoning County
Medical Society)

RESOLUTION NO. 21-75 Clarification of Resolution 23-74
(By the Gallia County Medical Society)

RESOLUTION NO. 22-75
Third Party Carriers
(By Sol Maggied, M.D., Delegate, Madison County Medical Society)

RESOLUTION NO. 23-75 AMA Fiscal Responsibility (By the Academy of Medicine of Columbus and Franklin County)

RESOLUTION NO. 24-75
Continuing Medical Education
(By the Academy of Medicine of Columbus and
Franklin County)

RESOLUTION NO. 25-75
Catholic Hospital Association
(By the Academy of Medicine of Cleveland and Cuyahoga County)

RESOLUTION NO. 26-75
Abortion Advertising
(By the Academy of Medicine of Cleveland and
Cuyahoga County)

RESOLUTION NO. 27-75
Special Committee to Analyze Published Health
Statistics for Dissemination to the Physicians
(By the Academy of Medicine of Cincinnati and
Hamilton County)

RESOLUTION NO. 28-75
Development of Outreach Program for
Heart Disease and Stroke
(By the Academy of Medicine of Cincinnati and
Hamilton County)

RESOLUTION NO. 29-75
Legislation to Protect Supply of a Life-Saving Drug
(By the Academy of Medicine of Cincinnati and
Hamilton County)

RESOLUTION NO. 30-75
Earlier Detection of Breast Cancer
(By William J. Flynn, M.D., Member, Mahoning
County Medical Society)

RESOLUTION NO. 31-75 Information-Medical Advances Institute (By the Huron County Medical Society)

RESOLUTION NO. 32-75 Surveys (By the Huron County Medical Society)

RESOLUTION NO. 33-75
Minutes of OSMA Council Meetings
(By the Huron County Medical Society)

RESOLUTION NO. 34-75 Itemizations-Costs-and Services Rendered (By the Huron County Medical Society)

RESOLUTION NO. 35-75 Combined Annual Dues and Assessments (By the Geauga County Medical Society)

- WHEREAS, combined annual dues and assessments for County, State (OSMA), and National (AMA) Medical Society dues are now well over \$300; and
- WHEREAS, the American Medical Association has adopted deficit financing necessitating unauthorized assessment of the membership to avoid bankruptcy; and
- WHEREAS, the membership apparently has no other means of asserting control over the endless proliferation of activities and related expenses with which such organizations tend to burden themselves, THEREFORE, BE IT
- RESOLVED, That a fixed dues level be set for the next five years, to include all dues and assessments, unless otherwise authorized by the membership, and which shall be no greater than \$100 annually for the Ohio State Medical Association and \$100 for the American Medical Association.

RESOLUTION NO. 36-75 Semi-Annual Meeting of OSMA House of Delegates (By the Stark Co. Medical Society)

- WHEREAS, activities of vital interest and importance to the Medical profession are taking place with markedly increasing frequency; and
- WHEREAS, the pace of such activities will almost certainly be intensified in the near future; and
- WHEREAS, the present system of only an annual meeting of the House of Delegates of the Ohio State Medical Association can result in as much as eleven months delay in discussion of vital issues; and
- WHEREAS, the House of Delegates of the American Association has found it imperative to meet at least semi-annually in an attempt to overcome such delays, NOW THEREFORE BE IT
- RESOLVED, That the House of Delegates of the Ohio State Medical Association meet semi-annually; the first meeting to be held in conjunction with the annual meeting of the Ohio State Medical Association in the same manner as presently constituted and the second meeting to take place in Columbus, Ohio approximately 30 days prior to the clinical meeting of the American Medical Association but in any event at an early enough time to allow resolutions from Ohio to be presented at the clinical meeting of the American Medical Association.

RESOLUTION NO. 37-75 Election of Councilors to OSMA (By the Huron County Medical Society)

RESOLVED, That in order to institute a more Democratic, Representative, Meaningful, and Responsible Process — hereafter — Councilors to the Ohio State Medical Association shall be nominated by the membership of the respective, representative districts approximately one month prior to the annual meeting of the Ohio State Medical Association. The names of the Councilors from each district thus elected shall be submitted to the Ohio State Medical Association nominating committee as final — there being only one nominee submitted from each representative district with the consent of said nominee.

RESOLUTION NO. 38-75 Election of District Councilors (By the Mahoning County Medical Society)

- WHEREAS, the individual delegates who make up the total delegation of each councilor district of the Ohio State Medical Association have been elected to office by the membership of their respective county medical societies within the councilor district; and
 - WHEREAS, these elected delegates know the problems and concerns of the members of their own county medical societies and of their own district better than anyone outside their district; and
- WHEREAS, it is customary for the delegation of each councilor district to meet in caucus and select by majority vote a nominee for the position of district councilor; and
- WHEREAS, under the present system, the name of the selected nominee must be submitted to the Nominating Committee of the Ohio State Medical Association, allowing that committee the decision as to whether that name or any other name may be placed in nomination; and
- WHEREAS, anyone nominated by the Nominating Committee is then subject to the vote of the entire House of Delegates in order to be elected to the position for which he has been nominated; and
- WHEREAS, the House of Delegates, under the present system, has the potential of electing a councilor who is not the choice of the majority of delegates within a district; THEREFORE BE IT

- RESOLVED, That the councilor of each district be elected (rather than nominated) by the delegation from his own district, with the consent of the House of Delegates, and that the House of Delegates be required to vote on a district councilor only in the case of a tie vote within that district's delegation; and BE IT FURTHER
- RESOLVED, That the elected councilor from a district be made aware that his basic responsibility is to the district which elected him and his secondary responsibility is to the Ohio State Medical Association; and BE IT FURTHER
- RESOLVED, That the necessary changes be made in the Constitution and Bylaws of the Ohio State Medical Association to permit each district to elect a councilor, rather than select a nominee for a councilor.

RESOLUTION NO. 39-75 Election of OSMA Councilors (By the Stark County Medical Society)

- WHEREAS, the Committee on Nominations of the House of Delegates of the Ohio State Medical Association is charged with selecting the nominee(s) for Councilor; and
- WHEREAS, the only present restriction regarding nominee(s) for Councilor is that the nominee must reside in the councilor district for which he is nominated; and
- WHEREAS, this present method of selection of nominees has, on occasions, led to intense politicking both in the Committee on Nominations and in the House of Delegates; and
- WHEREAS, such method of selection of nominee(s) and election of Councilors could result in election of a Councilor not representative of the majority membership of his district, thus effectively disenfranchising the membership of the affected district; THEREFORE, BE IT
- RESOLVED, That in those years in which a Councilor is to be elected, the district delegates to the Ohio State Medical Association shall meet not less than 14 days prior to the annual meeting and shall, by majority vote of those delegates present and voting, select one nominee for Councilor of their district; and BE IT FURTHER
- RESOLVED, That the nominee selected by said majority vote shall be the only nominee reported to the House of Delegates by the Committee on nominations, unless such nominee express in writing his unwillingness or his inability to serve; and BE IT FURTHER
- RESOLVED, That nominations from the floor for the position of Councilor shall not be permitted.

RESOLUTION NO. 40-75 Creating a Twelfth Councilor District (By the Summit County Medical Society)

- RESOLVED, That the House of Delegates with the authority granted to it by Section 6, Chapter 4 of the Bylaws of the Ohio State Medical Association, immediately establish Portage and Summit County Medical Societies as the Twelfth Councilor District of Ohio State Medical Association, removing them from the Sixth Councilor District, OSMA.
- BE IT FURTHER RESOLVED, That the president of OSMA immediately appoint a Councilor from this new district to serve until the 1976 annual meeting when he or she will stand for election with representatives of the other even-numbered OSMA Councilor Districts.

RESOLUTION NO. 41-75 Appointment of Members to Resolutions Committee (By the Council of the Mahoning County Medical Society)

- WHEREAS, the only voice that the individual physician member in Ohio has at the annual meeting of the OSMA House of Delegates is through the delegates whom he has elected from his own county to represent him; and
- WHEREAS, each delegate is both informed by, and responsive to, the individual members of his own county medical society who elected him to represent them; and
- WHEREAS, resolutions presented before the House of Delegates are the written testimony of the thoughts and actions of the individual members working together in their own county society meetings; and
- WHEREAS, the fate of these resolutions is greatly influenced by the composition of the Resolutions Committee to which it is assigned; and
- WHEREAS, in the past, appointments to each Committee on Resolutions has been made by the president of the Ohio State Medical Association in accordance with Chapter 4, Section 4, of the Bylaws of the Ohio State Medical Association; and
- WHEREAS, if it is to be a truly democratic organization, the Ohio State Medical Association must make every effort to reflect and enact the desires of its individual members, without whom there would be no Ohio State Medical Association, THEREFORE BE IT
- RESOLVED, That the power of appointment to Committees on Resolutions be given to the delegates from each of the eleven councilor districts, allowing each delegation to appoint one member to each Committee on Resolutions; and BE IT FURTHER
- RESOLVED, That the appointment of the members of the Committees on Resolutions be made after the assignment of resolutions to committee, so that an appropriate delegate may be assigned to the proper resolution committee, and BE IT FURTHER
- RESOLVED, That the president of the Ohio State Medical Association continue to appoint the chairman of each Resolutions Committee, and BE IT FURTHER
- RESOLVED. That Chapter 4, Section 4, of the Bylaws of the Ohio State Medical Association be changed to provide that appointments to resolutions committees be made by councilor district delegations.

RESOLUTION NO. 42-75 Voluntary Membership in OSMA (By the Council of the Mahoning County Medical Society)

- WHEREAS, membership in the American Medical Association is on a voluntary basis in the State of Ohio and many other states; and
- WHEREAS, membership in any county Medical Society in the United States is on a voluntary basis; and
- WHEREAS, membership in any medical professional organization, any specialty organization and any voluntary health agency is on a voluntary basis; and
- WHEREAS, the Mahoning County Medical Society, and probably a large number of other county medical societies in the State of Ohio, are losing members every year because said members refuse to belong to the Ohio State Medical Association, and therefore cannot belong to their county Medical Societies; and
- WHEREAS, a physician is entitled to refuse to pay money to an organization that he believes is using that money to advance legislation that will hinder and control his own personal practice of medicine; THEREFORE BE IT
- RESOLVED, That membership in the Ohio State Medi-

cal Association be on a voluntary basis; and BE IT **FURTHER**

RESOLVED, That the Constitution and Bylaws of the Ohio State Medical Association be changed to permit individual physicians to belong to their own county medical societies without belonging to the Ohio State Medical Association.

> **RESOLUTION NO. 43-75** Student Membership

(By the Council of the Ohio State Medical Association)
(1) RESOLVED, That Article III, Section 1, of the Constitution be amended by adding the following:

"(8) Student Members"

(2) RESOLVED, That Chapter 1, Section 2, of the Bylaws be amended by adding the following:

"(i) Student members. Student Members of this

Association shall comprise those students in good standing who are pursuing the diploma of Doctor of Medicine in an approved medical college

or institution in the State of Ohio."

(3) RESOLVED, That Chapter 1, Section 3, of the Bylaws be amended by adding the following in paragraph 1, line 2 after the word "honorary": "affiliate or student"

RESOLUTION NO. 44-75 Fiscal Notes

(By the Council of the Ohio State Medical Association) RESOLVED, That Chapter 4, Section 8 of the Bylaws

be amended to read as follows:

Section 8. Resolutions. Every resolution to be presented to the House of Delegates for action shall be filed with the Executive Director of the Association at least sixty (60) days prior to the first day of the meeting at which action on such resolution is proposed to be taken; and promptly upon the filing of any such resolution the Executive Director shall prepare and transmit a copy thereof to each member of the House of Delegates. "Each resolution which, if adopted, would require expenditure of funds by the Association, shall have attached, a statement of the amount of the estimated annual expenditure." No resolution may be presented or introduced at any meeting of the House of Delegates unless the foregoing requirements for filing and transmittal shall have been complied with or unless such compliance shall have been waived by a Special Committee on Emergency Resolutions named to decide whether late submission was justified. This special committee shall consist of the chairmen of the several resolution committees. If a majority of the members of the Special Committee on Emergency Resolutions vote favorably for waiving the filing and transmittal requirement, then such resolution shall be presented to the House of Delegates at its opening session. All resolutions presented subsequent to the 60-day filing date prior to the opening session of the House of Delegates shall be submitted by their sponsors to the committee no less than 12 hours prior to the opening session of the House of Delegates.

The Executive Director shall cause to be published

in The Journal, in advance of such meeting of the House of Delegates such resolutions as the President or the

Council may designate.

No consideration may be given, or any action taken, by the Committee on Resolutions or by the House of Delegates, with respect to any resolution unless such resolution shall have been presented or introduced at the opening session of the meeting of the House of Delegates; provided, however, that a resolution dealing with an event or development occurring too late to permit the introduction of any such resolution at the opening session may be introduced at a later session with the consent of at least four-fifths (4/5) of the delegates present; and upon its introduction, such resolution shall be referred to the Committee on Resolutions for consideration and report; and, provided further, that the Committee on Resolutions shall have the right to amend any resolution presented or introduced, or to draft a composite or substitute resolution embracing the same subject matter as that contained in a resolution or resolutions presented or introduced, and to submit such amended, composite or substitute resolution for adoption by the House of Delegates, and the House of Delegates

shall have the right to adopt any such amended, composite or substitute resolution.

> RESOLUTION NO. 45-75 Report on Professionalism

(By the Council of the Ohio State Medical Association)

RESOLUTION NO. 46-75

Publication of Budget
(By the Council of the Ohio State Medical Association)
RESOLVED, That Chapter 7, Section 5, of the Bylaws

be amended to read as follows:

"An Auditing and Appropriations Committee consisting of three members of the Council shall be appointed by the President, with the consent of the Council, to serve for one year. This Committee shall prescribe the method of accounting and shall audit any and all accounts of this Association. It shall prepare and present annually to the Council a budget providing for the necessary expenses of this Association. The budget, after approval by the Council, shall be published and distributed to the delegates and alternate delegates at least 90 days prior to the Annual Meeting. Any surplus or balance of funds for a given year shall revert to the general fund. The President, the President-Elect, the Immediate Past President and the Secretary-Treasurer shall be ex-officio members of such Committee with full voting rights."

> **RESOLUTION NO. 47-75** Affiliate Members

(By the Council of the Ohio State Medical Association) RESOLVED, that Article III, Section 1, of the Constitution be amended by adding the following:

"(7) Affiliate Members" and

RESOLVED, That Chapter 1, Section 2, of the Bylaws

be amended by adding the following:
"(h) Affiliate Members. Executives of the Ohio State Medical Association, county medical societies, and other medical organizations and specialty societies in Ohio with three years or more experience in the sponsoring organization are eligible for Affiliate Membership in the Ohio State Medical Association. Such Affiliate Membership shall be at the pleasure of the Council. An Affiliate Member shall pay no dues or assessments."

RESOLUTION NO. 48-75 Hearing Of Resolutions Involving Ethics (By the Council of the Ohio State Medical Association)

RESOLVED, That Chapter 7, Section 1, Paragraph 4, of the Bylaws be amended to read as follows:
"The Council shall be the board of censors of this Association, considering all questions involving the rights and standing of members, whether in relation to other members, to the component societies, or to this Association. All questions of an ethical nature brought before the House of Delegates involving the professional relations of individual physicians or groups of physicians shall be referred to the Council without discussion. The Council shall have full power and authority to hear and decide all questions. tions of discipline affecting the conduct of the members of this Association or the conduct of a component society. Its decisions in all cases, in-

cluding questions regarding the right of membership in this Association, shall be final." and RESOLVED, That Chapter 4, Section 4, paragraph 1 of the Bylaws be amended to read as follows: "Section 4. Committees of the House of Delegates. For the purpose of expediting proceedings the President shall appoint from the roster of delegates the following reference committees: Committee on President's Address; Committees on Resolutions, to which shall be referred all resolutions (except those of an ethical nature involving the professional relations of individual physicians or groups of physicians); Committee on Credentials; and other committees considered necessary by the President.

> RESOLUTION NO. 49-75 Abortion

(By N. M. Camardese, M.D., Delegate, Huron County Medical Society)

HOUSE OF DELEGATES

BUSINESS AGENDA

SUNDAY, MAY 11, 1975

3.00 - 7:00 p.m.

Registration for OSMA House of Delegates

Terrestrial Promenade, Second Floor Sheraton-Columbus Hotel

4:00 p.m.

Councilor District Caucus Meetings Sheraton-Columbus Hotel

District	Councilor	Room	Number	r
First	Stephen P. Hogg	Studio	Room	601
Second	James G. Tye	Studio	Room	623
Third	John C. Smithson	Studio	Room	801
Fourth	George N. Bates	Studio	Room	823
Fifth	John J. Gaughan	Taft R	oom (3r	rd Floor)
Sixth	C. Edward Pichette	Studio	Room	923
Seventh	Robert E. Rinderknecht	Studio	Room	1001
Eighth	Richard E. Hartle	Studio	Room	1023
Ninth	Thomas W. Morgan	Studio	Room	1101
Tenth	James C. McLarnan	Studio	Room	1123
Eleventh	Robert G. Thomas	Studio	Room	1201

5:30 p.m.

Buffet Dinner for Delegates, Alternates, OSMA Council and Official Guests

Mars and Venus Rooms, Second Floor Sheraton-Columbus Hotel

First Business Session, House of Delegates

7:00 p.m.

Call to order by the President — James L. Henry, M.D., Grove City

Invocation — Fr. Robert P. Neumeyer, Canton

Welcome by J. Hutchison Williams, M.D., Columbus, President, Academy of Medicine of Columbus and Franklin County

Report of the Committee on Credentials

Consideration of the Minutes of the last Annual Meeting (July 1974 issue of The Journal)

Introduction of honored guests

Report by the President of the Woman's Auxiliary
— Mrs. S. J. Glueck, Springfield

Presentation of AMA-ERF checks to representative of Ohio Medical Schools — Philip B.

Hardymon, M.D., Columbus, Chairman, Ohio Committee on AMA-ERF. University of Cincinnati College of Medicine; Case Western Reserve University School of Medicine; Ohio State University College of Medicine and the Medical College of Ohio at Toledo.

Presentation of plaques to Past Councilors and retiring AMA Delegates and Alternates; Chairman and members of Standing Committees and Chairmen of Special Committees.

Presentation of Life Memberships

Presentation of Distinguished Service Citation

Announcement of appointments to the Reference Committees by the President: Credentials; President's Address; Resolutions; and Tellers and Judges of Election.

Election of Committee on Nominations:

(Nominations from the floor. One representative (delegate) from each Councilor District. The committee shall report to the second and final session, Wednesday, May 14, 3:30 p.m., its recommendations in the form of a ticket containing nominees for offices to be filled at this meeting as required under the Constitution and Bylaws. Under the rotation plan established in 1963, the committeeman from the Second District shall serve as Chairman). The report of the Nominating Committee with respect to all offices except President-elect shall be posted at the registration desk, earliest time practicable and at least three hours before the final session of the House of Delegates.

President's Address:

James L. Henry, M.D., Grove City

Introduction of Presidents of other State Societies

Introduction of Resolutions:

(Resolutions must be introduced at this session of the House of Delegates, referred to the Reference Committees on Resolutions, and reported back to the House of Delegates at the Wednesday afternoon session before any action can be taken.)

Miscellaneous Business.

House of Delegates / continued

FINAL SESSION

WEDNESDAY, MAY 14, 1975

2:30 - 3:30 p.m.

Registration for OSMA House of Delegates Terrestrial Promenade, Second Floor Sheraton-Columbus Hotel

3:30 p.m.

Final Business Session, House of Delegates Jupiter and Saturn Rooms, Second Floor Sheraton-Columbus Hotel

6:00 p.m.

Buffet Dinner for Delegates, Alternates, OSMA Council and Official Guests Mars and Venus Rooms, Second Floor Sheraton-Columbus Hotel

BUSINESS AGENDA

Final Session, House of Delegates

3:30 p.m.

Introduction of Guests

Report of Committee on Credentials

Election of President-Elect

Report of Committee on Nominations and election of other officers

(a) Nominations for The Council (Members of The Council are elected for twoyear terms; terms of those representing the even-numbered districts expire in odd-numbered years)

Second District — (Incumbent, James G. Tye, M.D., Dayton)

Fourth District — (Incumbent, George N. Bates, M.D., Toledo) — Note: Ineligible for re-election, having served the maximum time on The Council as provided in the Constitution and Bylaws

Sixth District — (Incumbent, C. Edward Pichette, M.D., Youngstown)

Eighth District — (Incumbent, Richard E. Hartle, M.D., Lancaster)

Tenth District — (Incumbent, James C. McLarnan, M.D., Mt. Vernon) — Note: Ineligible for re-election, having served the maximum time on The Council as provided in the Constitution and Bylaws)

(b) Election of Delegates and Alternates to the American Medical Association — 5 Delegates and 5 Alternates to be elected each for a two-year term starting January 1, 1976 in compliance with the Constitution and Bylaws of the American Medical Association. The following incumbent Delegates and Alternates will serve for the remainder of 1975, their terms expiring December 31, 1975.

Delegates (listed alphabetically)

Oscar W. Clarke, M.D., Gallipolis Henry A. Crawford, M.D., Cleveland Harry K. Hines, M.D., Cincinnati W. J. Lewis, M.D., Dayton P. John Robechek, M.D., Cleveland

Alternates (Listed alphabetically)

George N. Bates, M.D., Toledo Richard L. Fulton, M.D., Columbus Jerry L. Hammon, M.D., West Milton Jack Schreiber, M.D., Canfield William R. Schultz, M.D., Wooster

All nominees for the office of AMA Delegates and AMA Alternates shall run at large.

Election of Delegates and Alternates of the AMA shall be governed by Section 6, Chapter 5 of the OSMA Constitution and Bwlays as revised by the House of Delegates in May, 1971.

Reports of Reference Committees.

President's Address

Resolutions Committee No. 1

Resolutions Committee No. 2

Resolutions Committee No. 3

Miscellaneous Business

Installation of Officers for 1975-1976

Announcement of Standing Committee Appointments by the newly installed President and action thereon by House of Delegates.

Unfinished business

Adjournment

MEMBERS OF THE 1975 HOUSE OF DELEGATES

Listed in the following columns are Delegates and Alternate Delegates to the Ohio State Medical Association House of Delegates, as reported from each county to represent their respective County Medical Societies at the 1975 OSMA Annual Meeting, May 11-14. All business sessions of the House of Delegates will be held at the Sheraton-Columbus Hotel, 50 North Third Street, Columbus, Ohio.

COUNTIES	
Delegates	Alternates
FIRST	DISTRICT
ADAMS Francis L. Stevens	William J. Lundy
BROWN John Donohoo	Andrew J. Pasquale
BUTLER Jerry D. Hammond James F. Stewart James M. Smith	Frank C. Palmer James I. Scott, Jr. Joseph Brandabur
CLERMONT Carl A. Minning	Wm. B. Selnick
CLINTON Foster J. Boyd	
HAMILTON John E. Albers Frederick Brockmeier Eugene J. Burns Edmund C. Casey Neal N. Earley Charles D. Feuss, Jr. George D. J. Griffin Robert S. Heidt Harry K. Hines Stephen P. Hogg H. Glenn Overley Glenn W. Pfister, Jr. William J. Schrimpf Andrew J. Weiss HIGHLAND Glenn B. Doan	Stewart B. Dunsker Harry H. Fox Robert J. Hasl George H. Kreyling James L. Leonard Ernest H. Meese Clyde S. Roof Walter B. Rugh, Jr. Harold S. Schiro Calvin F. Warner
WARREN Thomas E. Fox	Gary Hayes
SECOND	DISTRICT
CHAMPAIGN Isador Miller	John Flora
CLARK Ernest H. Winterhoff Henry A. Diederichs	Lawrence J. Mervis Carlos O. Andarsio
DARKE Jesse L. Heise	Jose R. Solis

Edward P. Call

Albert C. Howell

HENRY

Reynaldo C. Soriano

GREENE

MIAMI

Antonio Mannarino

A. Robert Davies

COUNTIES	
Delegates	Alternates
MONTGOMERY Benjamin Schuster A. J. Gabriele John H. Taylor R. Alan Baker W. J. Lewis	Konrad A. Kircher John R. Whitaker, Jr. Frederic C. Schnebly Robert K. Finley, Jr. Wallace E. Johnson
PREBLE Chester J. Brian	E. P. Trittschuh
SHELBY George J. Schroer	Jerome Mestemaker
THIRD	DISTRICT
ALLEN David A. Barr J. M. Oppenheim	Alexander C. Reed Robert L. Holladay
AUGLAIZE Robert J. Herman	Victor Stegall
CRAWFORD Johnson H. Chow	V. Allen Auchard
HANCOCK E. B. Davis	William Kose
HARDIN Robert B. Elliott	Jay E. Pfeiffer
LOGAN James H. Steiner	David R. Miller
MARION Paul E. Lyon	Ernest Hetrick
MERCER James Otis	Paul Beare
SENECA Walter Daniel	James Murray
VAN WERT A. C. Diller	Harold C. Smith
WYANDOT Joseph J. Browne	
FOURTH	DISTRICT
DEFIANCE Ben Lenhart	Paul E. Brose
FULTON Benjamin H. Reed, Jr.	William J. Neal

		IFS

Alternates Delegates **LUCAS** C. Douglass Ford Roland A. Gandy, Jr. Robert Hauman John A. Devany Robert Page B. Leslie Huffman George Asahina Harry L. Snyder Richard Wiseley M. Brodie James T. J. O'Grady Peter Overstreet **OTTAWA** John Bodie Patrick Hughes **PAULDING**

Doyt E. Farling

PUTNAM James Overmier John Brown

SANDUSKY Willis L. Damschroder

WILLIAMS John A. Moats Robert Dilworth

WOOD William Roberts

FIFTH DISTRICT

ASHTABULA Samuel L. Altier Harold C. Franley

CUYAHOGA A. Benedict Schneider, Jr. Gilbert Derian Hermann Menges, Jr. Richard Bright
Howard S. Siegel Nicholas DePiero
Edward J. Bishop Carl E. Zeithaml
Leonard L. Lovshin Richard J. Nowak
Lawrence J. McCormack Richard B. Fratianne Franklyn J. Simecek Edward F. Kieger, II Martin Broder J. Peter Fegen, Jr. Herbert Bell John H. Budd John K. Budd
John Kmieck
Theodore J. Castele
Henry A. Crawford
George P. Leicht
Clarence L. Huggins, Jr.
Vincent T. LaMaida
Herbert Bell
Hudson D. Fowler
Joseph Schultz
Robert C. Kirk
Casimir F. Radkowski
Clarence L. Huggins, Jr.
Roscoe J. Kennedy
Howard S. Van Ordstrand Thomas Paras Dennis Brooks Edward G. Kilroy Charles L. Cassady O. David Solomon Melvin Shafron P. John Robechek Morton Grossman George W. Petznick William M. Hegarty, Jr. Frederick T. Suppes Leroy Matthews Roland W. Moskowitz Richard P. Levy

GEAUGA Arturo Dimaculangan Bruce Andreas

John G. Poulos

LAKE John A. Bukovnick Wesley J. Pignolet Willis L. Irwin Joseph H. Myers

SIXTH DISTRICT

COLUMBIANA William S. Banfield Leonard S. Pritchard MAHONING

J. James Anderson C. Edward Pichette James Anderson W. Tandatnick William Moskalik William E. Sovik Jack Schreiber John C. Melnick Paul J. Mahar, Jr.

F. Michael Sheehan John Fulton

STARK Frank O. Goodnough Daniel A. Kibler E. Joel Davis William A. White, Jr. Edward E. Grable John D. Botti Brian S. Harrold

COUNTIES

Delegates Alternates SUMMIT Rocco M. Antenucci Roy E. Bugay Joseph L. Kloss Douglas M. Evans Emmett P. Monroe Charles East Richard H. Champion James G. Roberts W. Paul Kilway, Jr. Robert R. Clark

TRUMBULL Robert J. Paul Joseph L. Logan Harold L. Brodell Donald A. Miller

SEVENTH DISTRICT

BELMONT Theron R. Rolston Felipe V. Lavapies CARROLL Jack L. Maffett Carl A. Lincke COSHOCTON Norman L. Wright Robert R. Johnson HARRISON Elias Freeman Janis Trupovnieks

JEFFERSON Sanford Press Crist G. Strovilas

MONROE Donald Piatt

TUSCARAWAS Philip T. Doughten Harvey J. Reamy

EIGHTH DISTRICT

ATHENS John F. Kroner James R. Gaskell FAIRFIELD Darell Nicodemus James Merk **GUERNSEY**

Robert Ringer James Toland

LICKING John P. Anderson, Jr. Carl M. Frye

MORGAN Austin A. Coulson Henry Bachman

MUSKINGUM W. B. Devine Carl E. Spragg

NOBLE E. G. Ditch F. M. Cox

PERRY Ralph Herendeen, Jr. George C. Tedrow

WASHINGTON Gregory Krivchenia Mary Whitacre

NINTH DISTRICT

GALLIA Thomas P. Price Edward J. Berkich HOCKING Jan S. Matthews Lethia Starr **JACKSON** John Zimmerly Carl Greever LAWRENCE

A. Burton Payne Harry Nenni

MEIGS Roger P. Daniels

PIKE Kenneth E. Wilkinson Robert T. Leever COUNTIES

Delegates

Alternates

SCIOTO

Chester H. Allen

Carter L. Pitcher

VINTON

TENTH DISTRICT

DELAWARE

Robert S. Caulkins, Jr.

FAYETTE

Joseph M. Herbert

FRANKLIN Robert C. Atkinson James E. Barnes Keith DeVoe, Jr. Michael A. Anthony John N. Meagher Jack E. Tetirick Homer A. Anderson Joseph A. Bonta

J. Hutchison Williams KNOX

Henry Lapp MADISON Sol Maggied

MORROW

David J. Hickson PICKAWAY

Robert G. Smith

Joseph S. McKell

UNION John R. Linscott

Walter M. Haynes Ben E. Jacoby Donald W. Traphagen

F. M. Kapetansky H. Wm. Porterfield Philip H. Taylor Richard L. Fulton William A. Millhon William C. Earl

Adelbert R. Callander

Robert D. Woodmansee

Charles E. Cassaday

Charles T. Hay

William Deffinger

Ray Carroll

Richard Counts

Malcolm MacIvor

ELEVENTH DISTRICT

ASHLAND

Jon Cooperrider

Charles H. Warne

Delegates

COUNTIES

ERIE

S. Baird Pfahl, Jr.

Richard H. Williamson

HOLMES

Luther High

HURON

Nino M. Camardese

LORAIN Delbert L. Fischer

Harold E. McDonald Charles C. Adams

MEDINA Richard Avery

RICHLAND Harold F. Mills James W. Wiggin

WAYNE A. Burney Huff Alternates

Maurice Mullet

Earl R. McLoney

John Bartone Henry E. Kleinhenz Andrew Mattev

Rolland L. Mansell

Wendell M. Bell

James F. Clements

John Robinson

OFFICERS

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President-Elect	F.	Lieber
Past PresidentOscar	W.	Clarke
Secretary-Treasurer	M.	Wells

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First District Second District Third District Fourth District Sixth District Sixth District Seventh District Eighth District Ninth District	James G. Tye John C. Smithson George N. Bates John J. Gaughan C. Edward Pichette Robert E. Rinderknecht Richard E. Hartle
Eighth District Ninth District Tenth District Eleventh District	Thomas W. MorganJames C. McLarnan



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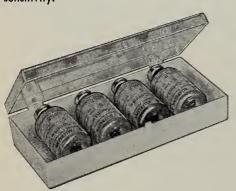
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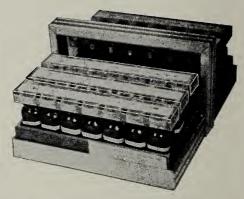
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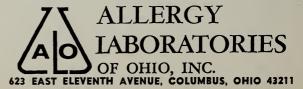
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OSMA Program Will Assist The 'Disabled Physician'

Details of a new OSMA program to assist physicians impaired by alcoholism, drug dependence or psychiatric disorders will be revealed in the near future by the newly-formed Subcommittee on Physician Effectiveness of the OSMA Committee on Mental Health.

OSMA Council recently approved the program in principle. The Subcommittee on Physician Effectiveness, however, has requested additional time to organize a formal operating structure Three members of the Subcommittee will attend the AMA's "Disabled Physician" conference on April 11-12 in San Francisco.

"The Subcommittee hopes to reach the physician before his problem affects his ability to practice," said Milton M. Parker, M.D., Columbus, chairman of the OSMA Committee on Mental Health. "Its goal will be to help the physician retain or regain his full effectiveness to practice medicine. Ideally, the Subcommittee will intercept the problem before it requires action by the Ohio State Medical Board on the physician's license."

Ohio physicians who recognize they have a problem will be encouraged to contact the Subcommittee on a strictly confidential basis. The Subcommittee will then cooperate in working out a treatment program with each physician. Peers of "disabled physicians" may also make the initial contact with the Subcommittee. The contacts between the peer and the Subcommittee will be on a strictly confidential basis.

Dr. Parker pointed out that county medical societies will be encouraged to set up local physician effectiveness committees. To do so, at least one Ohio county medical society is sending a representative to the San Francisco conference.

"In cases where the county medical society has no program or where the physician wishes to

go beyond his county boundaries for assistance," explained Dr. Parker, "the services of the OSMA Subcommittee on Physician Effectiveness will be available." Dr. Parker estimated that the Subcommittee would begin formal operation within three months.

Medical Asst's To Meet

The 18th Annual Convention of the American Association of Medical Assistants-Ohio State Society will be April 30-May 4 at the Sawmill Creek Lodge in Huron, Ohio. The Erie County Society of Medical Assistants will host the convention, which will focus on the "3-R's of Medicine — Re-education, Relaxation and Renewal."

The registration fee is \$45.00. For further information, contact Marilyn Zehringer, 112 Michigan Avenue, Sandusky, Ohio.

Assn. of Physicians Election

The Association of Physicians of the State of Ohio has announced its officers elected for 1975:

President

Mary Wiltberger, M.D., Toledo Mental Health

Vice Presidents

First, Angel Cadiz, M.D., Orient State Institute Second, Kurt Lessy, M.D., Marysville Reformatory for Women

Third, Zoltan Kontz, M.D., Athens Mental Health

Fourth, Maria Solymos, M.D., Hawthornden State Hospital

Secretary-Treasurer

Virginia S. Edwards, M.D., Massillon State Hospital



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Scioto Co. Gives Scholarships Honoring Dr. Alden B. Oakes

"Scioto County Medical Society and residents of Portsmouth are to be complimented for the formation and strong community support of the Dr. Alden B. Oakes Scholarship Fund," said James L. Henry, M.D., OSMA President.

Dr. Henry said the example set in Portsmouth could well be followed by other county medical societies and communities to recognize outstanding local physicians as well as help promising young men and women to become health care professionals.

Less than two years after the Scioto County Medical Society established a perpetual Scholarship Fund honoring Alden B. Oakes, M.D., seven outstanding students from the area were given grants to pursue their studies in medicine, premedicine, dentistry, nursing, and speech pathology.

On February 13, 1975, the Scioto County Medical Society established the fund in honor of Dr. Oakes, the first formally trained orthopedic surgeon to locate in Scioto County, for "his many contributions in the field of medicine, the community in general and, most importantly, his dedication and unselfish efforts on behalf of patients and colleagues."

Within two years, approximately \$25,000 had been raised. Recipients of the scholarship grants are encouraged to return to the area to practice.

OSMA Group Term Life Insurance Pays Dividend

Participants in the Ohio State Medical Association group term life insurance plan recently received a 291/2 percent dividend for the policy year ending August 31, 1974. The plan has a history of sizable dividends which have averaged 35.6 percent over the last four years.

Turner & Shepard, Inc., the plan's administrator, announced the dividend to the participants in February, 1975 and credited their semi-annual premium with the 29½ percent dividend.

This plan continues to provide members with a very low net cost protection. All members, including those who are incorporated, and their employees may enroll.

For additional information, please contact Turner & Shepard, Inc., 17 South High Street, Columbus 43215, telephone (614) 228-6115.

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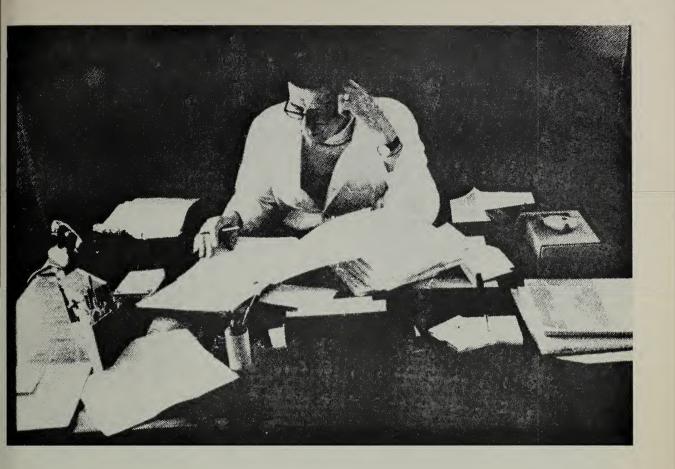
DESCRIPTION: Methyltestosterone is 178-Hydroxy-17-Methylandrost-4-en-3-one. ACTIONS: Methyltestosterone is an oil soluble androgenic hormone. INDICATIONS: In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and risss in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. PRECAUTIONS: Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. CONTRAINDICATIONS: Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. WARNINGS: If praipsims or other signs of excessive sex. au at simulation to evelop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or preoccious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. ADVERSE REACTIONS: Cholestatic jaundice • Oligospermia and dereased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This

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Following are names of new members of the Ohio State Medical Association certified to the headquarters office during February. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

Brown (Georgetown) Don Roy Shegog

Clark (Yellow Springs) Christian D. Thorpe

Cuyahoga (Cleveland) Julie Ann Clayman Henry W. Eisenberg Edward H. Gabelman Hon-Tjung Hew Muhammad R. Khokhar Licking (Granville) John F. Kreul Luciano A. Martinez Jafar Mobasseri Prabha S. Murthy Franklin B. Price James F. Rambasek Roger Rath Felisberto S. So Soen L. Tjoe Harvey J. West

Darke (New Madison) Shalbhadra Bafna

Franklin (Columbus) Daniel M. Lavigna, Jr. Garry H. Rupp Allen J. Sherrow

Fulton (Archbold) Dipak K. Sengupta Guernsey (Cambridge) Pedro E. Calderon Jose N. M. Sayat Nila Z. Sayat

Holmes (Millersburg) Lawrence S. Eby

Lake (Willoughby) Foo-Shon Chen

Richard A. Moyen

Lorain Razah U. Kherani Lorain Jose C. Ocampo Elyria Hian B. Oey Vermilion

Ronald A. Long Sylvania Joseph Manelis, Toledo

Marion (Marion) Abraham C. Kuttothara

Montgomery (Dayton) Young Joe Kwon

(Continued on Page 278)



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Ross (Chillicothe) Sun Y. Choi

Seneca (Tiffin) Chung-Hyo Kim

Stark (Canton except as noted) Allan B. Berggren, Massillon V. K. Bhachawat Lucila Corpus-Casabar John A. Frenz Harish C. Khera

Patrath S. Nuchikat Stanley F. Summerson D. Thiruppathi Minerva

Tuscarawas (Dover) Yogendra A. Shah

Michael R. Brocke Wooster Robert G. Reiheld Orrville Thomas C. Richard Wooster

Washington (Vincent) Gary L. Whitacre

Family Planning - Today's Choices is the title of the latest pamphlet in the Public Affairs series, now in its 39th year. The pamphlet summarizes findings on methods of contraception, giving special consideration to the problem of unwanted pregnancies among teenagers. It is available for 35 cents from the Public Affairs Committee, 381 Park Avenue South, New York, N.Y. 10016.

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Joseph S. Gonnella, M.D.
Alice Gosfield, J.D.
Floyd A. Grolle, Ph.D.
Clark C. Havifhurst, J.D.
Jay Hedgepeth, J.D.
Thomas O. Henteleff, J.D.

Reuben A. Kessel, Ph.D.
Gerald E. Lackey, J.D.
Richard O. Lempert, Ph.D., J.D.
Lawrence Lewin
Duke McCloud, J.D.
Gerald P. Moran, J.D., LL.M.
José L. Garcia Oller, M.D.
James A. Rice, J.D.
Alan K. Richards, J.D.
George J. Shieber, Ph.D.
E. Donald Shapiro, J.D.
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date			sig	gnature				

Woman's Auxiliary Highlights

Mrs. S. L. Meltzer, Communications Chairman 2442 Dorman Drive, Portsmouth 45662

It was the year 1940. The United States traded fifty destroyers to Great Britain. Franklin Delano Roosevelt won a third term. Germany invaded Norway and Denmark. The British retreated at Dunkirk. The Battle of Britain began. Alice Faye and Betty Grable were the "pinup girls." Charlie Chaplin's "Great Dictator" was released. Flying columns of females stormed the hosiery counters of department stores for the first big sale of nylon stockings. In New York, Grandma Moses had her first show. And in Columbus, Ohio, a new organization came into being — the Woman's Auxiliary to the Ohio State Medical Association. Thirty-five years ago, all of it.

This year's convention, again in Columbus, will celebrate the state auxiliary's "birthday." Presiding over the business sessions and special festivities will be Mrs. S. J. Glueck, 1974-75 president. She is a warm, articulate, knowledgeable, determined and dedicated leader. I'm afraid we don't pay enough tribute to our auxiliary presidents. Perhaps we just "take them for granted"! I'm confident that were I to ask Charlotte Glueck how many hours she has devoted to auxiliary this year, the figure would be astronomical and probably encompass most of her waking hours! Were I to ask Charlotte further how many miles she has travelled both by automobile and plane, she would need a computer to come up with the answer! No auxiliary president I have known — and I have known many of them — expect eulogies for what they have tried to do for our auxiliary. They accepted the job because they believed in the purpose and function of auxiliary. Yet I believe firmly they have all served "beyond the call of duty" and on this thirty-fifth anniversary, I present on behalf of Ohio's doctors and their wives this printed orchid for jobs well done.....

Convention 1975

The scene of activity will be the Christopher Inn on May 12, 13 and 14. Monday morning, May 12th, features the State Board pre-convention meeting to which the new 1975-76 board members are also invited — as they are to the Board luncheon that day. The afternoon lines up in this fashion: "Forecast 1975-76" for the incoming county auxiliary presidents and other county leaders (for orientation and discussion) to

be followed by "You Asked For It" (zeroing in on those special areas requested by the counties in their recent questionnaire answers).

High in priority as the Top of the Center itself (where the festivities will take place) is the Welcoming Dinner Monday night for all members, doctor-husbands and other guests. This is such a fine opportunity to meet, to mingle, to "savor" auxiliary friendship, and to get a beautiful view of our capital city. It has all the makings of a delightful evening, so get those reservations in early!

The very important business session gets under way at 9 a.m. Tuesday morning, May 13th, presided over by Charlotte Glueck, president. Mrs. Howard Liljestrand, president of the Woman's Auxiliary to the American Medical Association, will be Ohio's honored guest and will, of course, address the House of Delegates. "How to Laugh at Politics," delivered by Mark Russell, Washington's favorite humorist, will liven the OMPAC luncheon on Tuesday at noon. It's business again Tuesday afternoon until 4 p.m., following which there will be a reception in the suites of Mrs. Glueck and Mrs. Robert Krone, state presidentelect, for the old and new Board and for the outgoing and incoming county presidents and presidents-elect. It will be "OSMA-time" Tuesday night at the Country Dinner Playhouse in Reynoldsburg - and guess who's-coming-to-dinnerthere-too (well, he'll be there anyhow in a comedy) - none other than the appealing Van Johnson..... Wanna bet about the unprecedented turn-out?

Wednesday morning, May 14th, will be getup-very-early time (7:30 a.m.) for the President's Breakfast which will feature a "Summit Meeting." At 9:30 a.m., the third business session will be held. The installation of new officers will be conducted by Mrs. Liljestrand. And at 11:30 a.m., the Hamilton county auxiliary will hostess a reception in honor of its own Fran Krone and the new auxiliary officers and board. Comes the piece de resistance at twelve-thirty—the "Spring Love-In" luncheon honoring our national president as well as something mysteriously called "Special Helping Hands." I said "something" but of course

(Continued on Page 282)

The post-T&A patient:

another type for Tylenol acetaminophen products



When the post-T & A patient requires an analgesic, a new problem arises. Hemorrhagic tendencies following the use of aspirin after tonsillectomies have been reported. In a patient who "...has recently undergone a surgical procedure or has another underlying hemostatic defect, aspirin ingestion may cause significant bleeding.... Aspirin is absolutely contraindicated in such situations. Acetaminophen... could replace aspirin in these instances." 3

The post-T & A patient is only one of several 'types for TYLENOL' antipyretic-analgesic products—that is, patients who should avoid aspirin. Considering *all* of them, wouldn't it provide added safety (as well as added convenience) to recommend TYLENOL products routinely for simple analgesia?

References: 1. Reuter, S.H., and Montgomery, W.W.: Arch. Otolaryng. 80:214-217 (Aug.) 1964. 2. Osol, A., et al., ed.: The United States Dispensatory and Physicians' Pharmacology, ed. 26, Philadelphia, J.B. Lippincott Co., 1967, p. 171. 3. Schwartz, A.D., and Pearson, H.A.: J. Pediat. 78:558-560 (March) 1971.

Precautions and Adverse Reactions: If a rare sensitivity reaction occurs, the drug should be stopped. Acetaminophen has rarely been found to produce any side effects.

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it could be someone or two or three or more You'd just better come to this very extraspecial luncheon and find out for yourselves! An added feature will be guest speaker John Beljan, M.D., Dean, Wright State Medical School.

Two Special People

A salute to Mrs. Donal S. O'Leary, convention chairman, and Mrs. Patrick J. Creedon, convention co-chairman. 'Tis said that if you want a job well done, give it to a busy person. Here are some bits of "biography" I've garnered to prove my point: Mary O'Leary hails originally from Pittsburgh and has been a member of the Franklin auxiliary since 1960. Her husband's specialty is OB-Gyn. She is the mother of five children. She is a nurse and former TWA hostess. She helps out in her husband's office. Peggy Creedon comes

from Buffalo, New York and has been an auxiliary member since 1964. Her husband is a surgeon. She is the mother of four children, all under seven years of age! Peggy and her husband are known for their culinary skills. She is a nurse and helps out in her husband's office. I did say "two busy people," didn't I?

Other Franklin convention committee chairmen include: Mrs. Donald Lewis; Mrs. Floyd Beman; Mrs. Dale Dickens; Mrs. Richard Fulton; Mrs. Paul Metzger; Mrs. Horace Davidson; Mrs. Ed Klopfer; Mrs. Dan McFarland; Mrs. Richard O'Brien; Mrs. Robert Mounts; Mrs. Brooks Hurd; Mrs. Greg Castetter; Mrs. Herbert Bean; Mrs. James Best; Mrs. Chester Bennett; Mrs. Ronald Mezger; Mrs. Harold Long; Mrs. George Kress.

This is our "thirty-fifth." C'mon and help us celebrate!

Family Practice Board To Give Certification Exam Nov. 1-2

The American Board of Family Practice will administer its next two-day written certification examination on November 1-2, 1975. The exam will be given at five centers geographically distributed throughout the United States. Any physician desiring to take the exam must file a completed application with the Board office by June 15. A non-refundable \$50.00 application fee should be submitted with the application.

Information about the exam may be obtained by writing: Nicholas J. Pisacano, M.D.

Secretary
American Board of Family Practice, Inc.
University of Kentucky Medical Center
Annex #2, Room 229

Lexington, Ky. 40506

Battelle's X-Ray Device May Detect Early Breast Cancer

Laser-generated X-rays show promise as a new tool in early detection of breast cancer and other medical and biological applications. In the X-ray probe under development at Battelle's Columbus Laboratories, a powerful laser beam is used to produce X-rays emitted from the tip of the cone-like device.

The new device has an X-ray source offering a unique combination of small source diameter, fast exposure time, and soft X-rays. These features permit high-resolution X-ray photographs. Such photographs can eliminate blurring due to bodily motions and will hopefully provide distinct images of small incipient tumors.

Research on the new probe has been supported by Battelle and the North Central Health Foundation, Wausau, Wisconsin.



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Obituaries

George J. Hance, M.D., Troy; University of Cincinnati College of Medicine, 1918; age 86; died February 5; member of OSMA and AMA.

Chester R. Jablonski, M.D., Cleveland; St. Louis University School of Medicine, 1934; age 69; died February 17; member of OSMA and AMA.

Hugh K. Long, M.D., Bronxeville, N.Y.; Ohio State University College of Medicine, 1935; age 67; died February 14.

Henry Luidens, M.D., Columbus; Rush Medical College, 1927; age 75; died February 10; former member of OSMA and AMA.

Sterling Obenour, Sr., M.D., Zanesville; Ohio State University College of Medicine, 1928; age 73; died February 5; member of OSMA and AMA.

Gwyn A. Parry, M.D., Jackson; Ohio State University College of Medicine, 1933; age 67;

died February 10; member of OSMA and former member of AMA.

William Philip Smith, Jr., M.D., Columbus; Ohio State University College of Medicine, 1947; age 52; died February 17; member of OSMA and AMA.

Pearl Clifford Staker, M.D., Columbus; Ohio State University College of Medicine, 1925; age 79; died January 29; member of OSMA and AMA.

Victor Lucius Tanno, M.D., Cleveland; Western Reserve University School of Medicine, 1918; age 82; died February 6; member of OSMA and AMA.

Louis M. Timko, M.D., Cleveland; University of Maryland School of Medicine, 1921; age 78; died February 16.

Dominic Louis Zaworski, M.D., Lorain; Eclectic Medical College, 1927; age 74; died February 9; member of OSMA and AMA.

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country. Its services are widely used. Hundreds of inquiries are received and answered from all segments of the community, from coast to coast.

To trigger grass-roots action, we have formulated a model State Cancer Remedy Act designed to control the promotion and sale of unproven methods of cancer management. This has already inspired nine states to legislate against cancer quackery—with active support from the medical community. Copies of the model act, as well as copies of the laws in effect, are available in our National and Division offices.

In these actions against cancer quackery, as in all our efforts against cancer, ours is a lifesaving partnership.

> American Cancer Society

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CONTINUING EDUCATION OPPORTUNITIES

Ohio Colleges

Cleveland Clinic Educational Foundation

For further information: 9500 Euclid Ave. Cleveland 44106

Diagnostic Immunology; April 23-24; \$80. New Advances in Dermatology; May 15-16; \$80.

Case Western Reserve University

For further information: School of Medicine 2109 Adelbert Road Cleveland 44106

Medicine 1975; May 7-10; \$150.

Ohio State University

For further information: Center for Cont. Medical Education 320 West Tenth Ave. Columbus 43210

Practical Perimetry for Beginners; April 14-15; \$70. Electronystography Conference; May 21-22; \$100. Advances in Middle Ear Effusion; May 29-31.

University of Cincinnati

For further information: Office of CONMED 234 Goodman St. Cincinnati 45229

Abdominal Surgery; April 30-May 1; \$100; \$50 for residents.

Advances in Internal Medicine; May 19-23; cosponsored by American College of Physicians; \$140 for ACP members, FACP and residents; \$200 for non-members; \$70 for ACP Assoc.

—Cincinnati Mental Retardation; June 13; 9 a.m.; 36th Benjamin Knox Rachford Symposium; Research Auditorium of Children's Hospital Research Foundation.

In Ohio

Family Relations Workshop on Family Dynamics; April 25-27; Salt Fork Lodge, Cambridge; sponsored by Ohio Academy of Family Physicians; \$50 for members; \$65 for non-members.

Biomechanics; April 28-May 2; Cleveland Plaza, Cleveland; sponsored by American Academy of Orthopaedic Surgeons; \$150 for members; \$250 for non-members; \$125 for residents.

Impact of Federal Regulation of the Health Delivery System — May 1-3; a colloquium of the University of Toledo College of Law; for further information, contact William E. Higley II, Associate Editor, Law Review, 2801 West Bancroft St., Toledo 43606.

Adult Foot, Medical and Surgical Management; May 4-7; Stouffer's Cincinnati Inn, Cincinnati; Sponsored by American Academy of Orthopaedic Surgeons; \$200 for MD's; \$150 for AAOS members; \$100 for residents.

Newborn; May 8-10; Miami Valley Hospital, Dayton; co-sponsored by American Academy of Pediatrics; \$75 for members; \$105 for non-members.

Diagnostic Roentgenology; May 27-31; contact: Harold B. Spitz, M.D., Dept. of Radiology, Cincinnati General Hospital, Cincinnati.

Microneurosurgery Symposium; May 29-31; Cincinnati Convention Center; sponsored by Departments of Neurosurgery, The Christ and Good Samaritan Hospital; contact: S. Stuckey, 506 Oak St., Cincinnati 45219.

Emergencies In Cardiology; April 29-30; sponsored by Akron District Chapter of the American Heart Association; E. J. Thomas Performing Arts Center of the University of Akron.

Diagnostic Criteria in Abdominal Echography; May 7; 8-9 p.m.; Hitchcock Auditorium, South Unit, Youngstown Hospital Association, Youngstown.

Ultrasound, A New Diagnostic Field; May 8; 8-9 p.m.; Heberding Memorial Lecture; Hitchcock Auditorium; South Unit, Youngstown Hospital Association, Youngstown.

Fifth Annual Radiological Seminar; June 11; 8:30 a.m.-4:15 p.m.; Veterans Administration Center, Dayton; contact: Emil Gutman, M.D., Chief, Radiology Service, Veterans Administration Center, Dayton 45428.

Outside Ohio

Scientific Assembly on Emergency Medicine; April 21-23; Fairmont Colony Square Hotel; Atlanta, Ga.

Recent Progress in Clinical Endocrinology: Physiological Approach to Diagnosis and Treatment; April 21-25; University of Michigan Medical Center, Ann Arbor; co-sponsored by American College of Physicians.

Gastroenterology for Practicing Physicians — April 24-26; sponsored by American College of Physicians; S. S. Kresge Learning Resources Center of Meharry Medical College, Nashville, Tenn.

Seminar on Law and Medicine; April 24-26; University of Kentucky, Colleges of Medicine and Law: Law Building Auditorium; Lexington; \$65.

Selected Topics in Internal Medicine — May 8-10; sponsored by American College of Physicians; Washington Hospital Center, Washington, D.C.

Clinical Aspects and Treatment of Rheumatic Diseases; May 8; sponsored by University of Louisville School of Medicine; contact: D. H. Neustadt, M.D., Univ. of Louisville.

Recent Developments in Medical Oncology; May 12-14; sponsored by American College of Physicians; 19 S. 22nd St., Philadelphia.

Clinical Auscultation of the Heart; May 14-16; sponsored by American College of Physicians; at Georgetown University Medical Center's Gorman Auditorium.

National Symposium on Genetics and the Law; Mav 19-20; contact: Dr. Milunsky, Genetics Unit, Massachusetts General Hospital, Boston 02114; co-sponsored by American Society of Law and Medicine and National Genetics Foundation.

11th Annual Postgraduate Symposium on Rheumatic Diseases — May 8; Health Sciences Center, University of Louisville School of Medicine. Contact: David H. Neustadt, M.D., Univ. of Louisville School of Medicine.

First Forum; sponsored by American Medical Association and Public Safety Officers Foundation; April 22; Hyatt Regency, Chicago, Ill.; \$75.

National Socioeconomic Congress; April 26-26; sponsored by American Medical Association; Hyatt Regency, Atlanta, Ga.; \$50; \$10 for interns, residents and medical students

Pulmonary Disease: The Changing Scene; April 30-May 2; University of Toronto, Medical Sciences Building, Toronto, Ontario, Canada; contact: Bradford W. Claxton, American College of Chest Physicians, 911 Busse Highway, Park Ridge, Ill. 60068.

Fractures and Other Trauma; May 7-10; Sheraton-Chicago Hotel, Chicago; sponsored by Chicago Committee on Trauma of the American College of Surgeons; contact: American College of Surgeons, 55 East Erie St., Chicago, Ill. 60611; \$150; \$45 for interns, residents, and allied health personnel.

Surgery Review; June 1-5; University of Kentucky Medical Center, Lexington, Kty.; contact: Frank R. Lemon, M.D.; \$175.

Refresher Seminar in Pediatrics; June 2-6; contact: Continuing Medical Education, 2211 Main St., Buffalo, N.Y. 14214.

Emergency Medical Care — Medicolegal Implicacations; June 8-10; Statler Hilton Hotel, Washington D.C.; contact American Society of Law & Medicine, 454 Brookline Ave., Boston, Mass. 02215; \$150 for nonmembers; \$135 for members; \$20 for students.

27th Annual Meeting, Pennsylvania Allergy Association; June 13-15; Hotel Hershey, Hershey, Pa.

Hypertension 1975; June 26; University of Kentucky Medical Center, Lexington, Kty.; contact: Frank R. Lemon, M.D.; \$20.

Cardio-Pulmonary Emergencies; June 27-28; University of Kentucky Medical Center, Lexington, Kty.; contact: Frank R. Lemon, M.D.; \$75.

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In This Issue:

Air Force Opportunities275
Allergy Laboratories of Ohio, Inc270
The Brown Pharmaceutical Co., Inc252, 256, 274
Burroughs Wellcome Co226
The Christopher Inn243
Daniels-Head & Associates, Inc278
Dorsey Laboratories, Div. of Sandoz-Wander, Inc
Flint Laboratories, Div. of Travenol Lab. Inc245, 246, 247, 248, 265, 266
Harding Hospital283

Immke Circle Leasing276
International Travel Advisors, Inc
Lilly, Eli and Company212
Maritz Travel Associates272
McNeil Laboratories
Mead Johnson Laboratories258
The Medical Protective Company240
Menendian, K.A. Carpets237
Pharmaceutical Manufacturers Association
Roche Laboratories, Div. of Hoffman- LaRoche, Inc Inside Front Cover, 209, Inside Back Cover, Back Cover
Roerig & Co., Div., Pfizer228
Schmidt's Sausage Haus269
Searle Laboratories, Div. of G.D. Searle & Co
Searle Laboratories, Div. of G.D. Searle & Co
SK&F Co., Subsidiary of Smith, Kline
SK&F Co., Subsidiary of Smith, Kline & French Laboratories227
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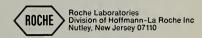
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Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies.

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Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle

spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.





VOL. 71

MAY, 1975

NO. 5

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Need Films For Annual Chest Physicians' Meeting

The Motion Picture Program Committee of the American College of Chest Physicians announced its "Call for Scientific Motion Pictures." Films submitted to the Committee will be reviewed for acceptance in the Motion Picture Program of the 41st Annual Scientific Assembly of the College. The five-day medical meeting will be held in Anaheim, California, October 26-30, 1975.

Subject matter of the submitted films should be in the realms of circulation, respiration, thoracic/cardiovascular surgery and related systems. There are no restrictions concerning the length of the films. The Motion Picture Program will include discussion periods following film presentations. Deadline for submission of films is May 30, 1975.

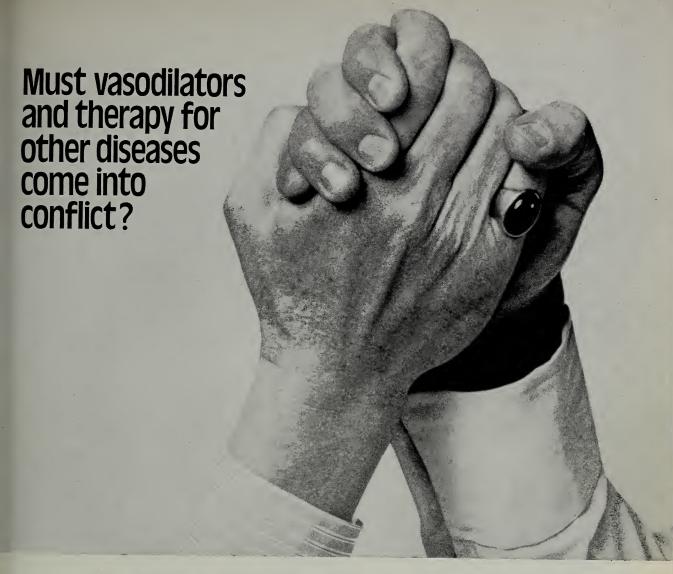
For film application forms, please write to: Constantine J. Tatooles, M.D. Chairman, Motion Picture Program American College of Chest Physicians 911 Busse Highway Park Ridge, Ill. 60068 Film authors will be notified of the Committee's decision, upon completion of the reviewing sessions in mid-June.

Student Association Changes Name To Sever Affiliations With AMA

In the final afternoon session of its 25th Annual Meeting, the Student American Medical Association (SAMA) officially severed any implied affiliations with the American Medical Association. The student group adopted a new name—the American Medical Student Association (AMSA).

The name change barely received the twothirds margin of approval necessary for adoption, passing 70-35. Two days of heated debate in the House of Delegates and three previous ballots preceded adoption of the name change. Proponents of the change argued that recruiting members was a problem due to the association of SAMA with the AMA. The AMA founded SAMA in 1950 and supported it during the early years, although SAMA is officially an independent student organization.

During the Annual Meeting, Laurie Cappa, from Case Western Reserve University, was elected as the AMSA's first president. She is the student organization's first woman president ever. The Annual Meeting was held in Chicago during March.



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Human Rabies Immune Globulin Now Available Around Ohio

JOHN H. ACKERMAN, M.D., M.P.H. Director, Ohio Department of Health

MICHAEL R. JENNINGS, M.D. Ohio Department of Health

Human Rabies Immune Globulin (HRIG) became commercially available in October, 1974 through Cutter Laboratories. It was in limited supply initially, and was available only through two distribution centers, one of which was in Texas. and the other in California. Due to the limited supply, the Advisory Committee on Immunization Practices recommended that it be used only for patients who are known to be hypersensitive to horse serum, are skin-test positive to antirabies serum of equine origin, or are pregnant, and require post-exposure treatment with hyperimmune rabies antiserum.1

The manufacturer has recently made Human Rabies Immune Globulin available on a general basis in Ohio. A stockpile system of distribution has been arranged so that globulin is available throughout the state, and within three hours of all locations. Stocks of Human Rabies Immune Globulin will be maintained by the distributors listed at the end of this discussion. In order to acquire HRIG, contact the nearest distributor, who will arrange for transportation of HRIG to the location of the patient.

Human Rabies Immune Globulin is prepared from pools of human plasma with high rabies antibody titer from immunized volunteers. It has been shown to produce titers equivalent to those from equine rabies immune globulin currently in use.^{2,3} HRIG has been demonstrated to have the same magnitude of suppression of antibody response to rabies vaccine as equine globulin. For this reason, the recommendations in regard to vaccine administration in conjunction with HRIG are the same as for equine globulin. When hyperimmune serum and vaccine is administered for post-exposure rabies prophylaxis, 21 doses of vaccine plus booster doses on the 10th and 20th day after completion of the

When impotence due to



DESCRIPTION: Methyltestosterone is 178-Hydroxy-17-Methylandrost-4-en-3-one. ACTIONS: Methyltestosterone is an oil soluble androgenic hormone. INDICATIONS: In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. PRECAUTIONS: Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. CONTRAINDICATIONS: Contraindicated in persons with known or suspected cardinoma of the prostate and in cardinoma of the male breast. Contraindicated in the presence of severe liver damage. WARNINGS: If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or preoccious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carc

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initial course should be administered, in addition to usual wound care.4

In order to monitor vaccine usage, and to provide data on antibody responses, a notification card is provided with each vial of HRIG. The physician administering the globulin is requested to fill out the card and mail it to the Center for Disease Control, Atlanta, Georgia. The Ohio Department of Health will be notified by the Center for Disease Control of each case in Ohio. A letter is then sent to the physician requesting that he submit a serum specimen from the patient 30-60 days after the initiation of treatment, to the Ohio Department of Health Laboratories, 1571 Perry Street, Columbus, Ohio for determination of serum neutralizing antibody titers in order to monitor the effectiveness of the vaccination program.

The HRIG is supplied in 2 ml. and 10 ml. vials with a potency of 150 International Units/ml. The recommended dose is 20 IU/kg. (0.133 ml./ kg.) of body weight in a single administration. As much as one half of the dose should be used to infiltrate the wound, and the rest administered intramuscularly. HRIG should not be administered intravenously.

The availability of HRIG represents a significant step forward in rabies post-exposure prophylaxis. Side effects are rare and consist almost entirely of local erythema and pain. The problem of allergic reactions, notably serum sickness, following administration of equine immune globulin is circumvented. Reactions following administration of equine rabies globulin have been reported in from 16-40% of patients in various studies.⁵ The major problem with HRIG at present would appear to be the cost. The product is quite expensive at present, and this aspect should be considered by physician and patient in choosing between human and equine globulin.

Human Rabies Immune Globulin Distributors

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McKesson & Robbins Drug Co. 4625 Manufacturing Road Cleveland, Ohio 44135 Phone: 216-267-7700

Bailey Drug Co. 1000 Linden Avenue Zanesville, Ohio 43701 Phone: 614-453-0591

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Cutter Laboratories 4015 Fondorf Drive Columbus, Ohio 43228 Phone: 614-276-5461 (24 hour Number)

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Construction of a Mastery-Oriented Teaching Unit Using a Minicomputer

Stephen J. Mayor, Ph.D.

The design of mastery-oriented teaching units is discussed and exemplified in relation to incorporating principles of educational psychology, writing performance objectives, and other principles. A discussion of implementing these units with a minicomputer is also included.

EDITOR'S NOTE:—All physicians involved in teaching students (residents, interns, medical students, student nurses, and allied health students) in the hospital setting would be well-advised to carefully evaluate Professor Mayor's article.

His emphasis on the student's motivation and the student's previous experience and knowledge (entry-level) of the subject under study are applicable at all levels.

THE PURPOSE OF A mastery-oriented teaching unit is to get each student to perform at a high level on a given body of material. In practical terms, this amounts to a form of educational quality control. The argument for adopting this philosophy of teaching for medical students can be simply illustrated by asking the following question: How many people would be interested in flying with a pilot who got a grade of 90 percent in take-off but only 50 percent in landing (an average "passing" grade of 70 per-

The question, "What do I want the students to be able to do with the information included in the objectives of this study course?" needs careful evaluation. In the past, too much emphasis was spent on memory exercises—"does the student know what I know (my textbook, my research, etc.) — and not on functional performance objectives.

Let us not repeat the errors of our student days in the education of today's students.—R.L.M.

cent)? Similarly, few patients would want to endure comparable variability of skills or competency in a physician. Thus, recognizing the need for such teaching units, the purpose of this paper is to illustrate how they might be constructed and used.

Methods and Discussion

A properly constructed mastery-oriented teaching unit must include or consider (1) the motivation of the student about to learn the material; (2) the background or "entry level" of the student; (3) well-defined, functional objectives; (4) a prescribed criterion of acceptable performance on those objectives; (5) a system of

Dr. Mayor, Toledo, Assistant Professor of Physiology, Medical College of Ohio at Toledo. Submitted January 12, 1975.

feedback which immediately informs the student of his progress (and is also available to the instructor for his assistance at a later time); (6) the opportunity for the student to practice meeting the unit's criterion. Among the items of lesser importance which should nonetheless be considered are: (7) the length of the presentation; (8) the sequencing of the material to be presented, (9) the scheme of presentation; and (10) evaluation and revision of the unit. Viewed in the whole, then, a mastery-oriented teaching unit must use the above elements to present information to the student (ie, through lectures, discussions, or selfinstruction) and also to develop his ability through practice to use the material to a high level. The following is an example of how to develop these points using some typical subject material encountered by first-year medical students: The Physiological Basis of Transmembrane Potentials.

1. Motivation — Acquisition of information can be accelerated, as well as made more enjoyable and easier if it is placed in the context of the students' overall goals. In other words, students invariably will be poorer performers if no thought is given to the relevancy of the material they are about to learn. Consequently, instead of telling the students that they will learn about transmembrane potentials, as the case in point, they are told:

"A patient presents with flaccid muscle paralysis and abnormalities in his ECG pattern. Effective treatment of these symptoms depends on your understanding of the basis of transmembrane potentials. This is an example of the clinical relevancy of the material that you are about to learn."

2. Entry Level — Failure of any teaching unit is inevitable if the performance demanded of the student is not within his behavioral repertoire. Consequently, it is encumbent upon the instructor to ascertain if his students have the background necessary to learn the new material. Part of this burden, of course, must be shared by the school's admissions committee and its entrance requirements and screening procedures.

The traditional approach used to determine entry level is a post hoc analysis of the previous class's performance on a given body of material and the extrapolation of this information to the next class. Because of variability in the educational background of each new class, a better approach is the administration of a series of short precourse quizzes (pretests) to each class on the material they are about to learn. An item analysis of properly constructed pretests can then be used by the instructor to formulate a plan of instruction to the new class.^{1,2}

3. Functional Objectives — Perhaps one of the most difficult tasks an instructor must face in designing a teaching unit is the selection of the information he wishes to transmit to the student. The typical approach in formulating course objectives is: What do I want the students to know? Much to the students' consternation, this usually results in a discursive assemblage of facts. It also makes the construction of a test very difficult. A better approach which delimits the facts and facilitates testing is: What do I want the students to be able to do with this information? The emphasis on "do" rather than "know" helps convert the objectives into "performance" or "functional" objectives. Thus, by using this approach, the instructor will find it much easier to assemble the facts that the student requires. In addition to increasing the specificity of performance required, functional objectives orient the construction of examinations toward behaviorally measurable items. Thus, as a functional goal in the study of transmembrane potentials, the student is told: "You will be able to predict the consequences of changing the internal and external ionic environment of electrically excitable cells (nerve and muscle) on the resting membrane and action potential of those cells;" as opposed to: "You will know the basis of transmembrane potentials."

4. Performance Criterion — Using the test items formulated from the unit's functional objectives, the instructor must make a decision as to the level of performance required of the student. This criterion should be commensurate with the difficulty of the test items, the entry level of the students, and the time available for teaching. Using the example of the author's unit on transmembrane potentials, it was found that first-year medical students could readily achieve a 90 percent-correct response criterion for two consecutive problem sets.

Another important aspect of the performance criterion is that it should be established prior to the actual instructional experience and should be applied uniformly to all students. Post hoc attempts to decide what is acceptable performance only vitiate the concept of mastery learning.

5. Feedback — An approach often used to inform a student of his progress is the comprehensive examination administered at appropriate intervals during a course of instruction. Frequently these are limited to two examinations, a midterm and a final, which are scored and the results returned some time later to the students. However, in too many instances, the long latency of such feedback reduces the value of the examination for the student. For example, the student may be informed of his performance at a point where he is well into new material and has little time for remedial education. In addition, the contingencies for the reinforcement of the student's responses are usually inappropriate and, as a result, acquisition is retarded. Such a system of

examination also entails a high risk of misrepresenting the student's state of learning. Because these tests are infrequently administered, deficiencies in performance due to nonrelated behavioral variables may be mistaken for deficits in learning. Another drawback to infrequent, discrete measures of performance is that they often represent the only opportunity for the student to learn what is expected of him. Finally, because the element of practice is missing, infrequent examinations merely tend to serve as a device to discriminate between fast and slow learners.

In order to circumvent the afore-mentioned problems encountered in the traditional method of providing feedback, the students studying transmembrane potentials were exposed, with the aid of a minicomputer, to a series of "equivalent" problem sets. 1 Use of the computer's ability to provide immediate feedback allows the student's responses to become potent reinforcers in the acquisition of information. In addition, the minicomputer can be used to provide feedback to the instructor in the form of individual student-learning curves for each functional objective. Such a longitudinal measure is a more accurate indicator of performance than a single comprehensive examination. For example, response variations due to sensory, motor, or motivational changes tend to average out over time. Last, because the minicomputer interacts with students on an individual basis, the feedback is tailored to the individual's learning rate, thus helping to minimize the performance difference between fast and slow learners.

6. Practice — Learning by successive approximations or practice, is desirable because it facilitates the establishment of long-term memory.

The manner in which practice was introduced for the teaching unit on transmembrane potentials was to fractionate the unit's functional objective into five subobjectives. Using one multiple-choice question (five choices per question) for each subobjective, a series of five problem sets (five questions per problem set) was constructed (a total of 25 questions). Taken through all five problem sets, each question constitutes a series of five different trials on the same subobjective and each problem set constitutes a different trial on all five subobjectives, ie, one major functional objective.

- 7. Length of Presentation Each unit should be constructed so that a student could go through it at his own rate. But it should be brief enough so that even the slowest or least motivated student can respond to the entire contents of any of its components within an hour.
- 8. Sequencing of Material Each step in the presentation of the material should be brief and as encompassing of a point as possible. It is

also helpful, if possible, to provide some graphic illustration of the point and to elicit a response to it.

9. Scheme of Presentation — A mastery-oriented teaching unit may be presented in a variety of ways depending on the availability of personnel, audiovisual resources, and the predilection of the students. The scheme used by the author consisted of the following sequence of events: (1) presentation of the functional objectives (handout); (2) pretest; (3) assigned reading; (4) class discussion; (5) audiovisual unit; (6) computer model; (7) mastery-training; and (8) post-test. While individualized education (beginning with item 5) was elective, all students were required to take the post-test.

In the computer-model portion of the presentation, the student can change ion concentrations and membrane permeabilities, predict the possible changes in the magnitude of the resting membrane potential and action potential, and compare the computer plot of the wave forms on the cathode ray tube with his prediction.

If, in the mastery phase of the schemata, a student exhausts all five problem sets without reaching the criterion, the instructor, based on an analysis of the student's subobjective-learning curves, determines the proper remedial steps to rectify the performance deficit. These may include reviewing the audio-visual model, the computer model, and a new series of problem sets.

10. Evaluation and Revision of the Unit — Evaluation and revision of the author's teaching unit was based on a comparison of the post-test performance of students taught in the "group mode" (items 1 through 4) versus those receiving individualized education (items 5 through 7).

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Carcinoembryonic Antigen (CEA) A New Diagnostic Tool

Edward W. Martin, Jr., M.D. William E. Kibbey, M.D. John P. Minton, M.D., Ph.D.

> CEA is not a screening test for malignant tumors and should not be considered a substitute for sound clinical judgment, rectal examination, sigmoidoscopy, and barium studies. Preoperative and postoperative CEA titers are important in the evaluation of the effectiveness of surgery and the progression of the disease entity.

CEVERAL YEARS OF EXPERIENCE with O carcinoembryonic antigen (CEA) at The Ohio State University Hospitals has greatly enhanced our knowledge of the use of this diagnostic tool. It must be stressed that CEA is not a screening test for carcinoma. It is a tool that can be of great value in diagnosing colorectal carcinoma, when combined with a complete medical history, rectal examination, guaiac test, sigmoidoscopy, and barium enema. Postoperatively, it acts as a sensitive indicator of residual or recurrent malignancy. The usefulness of CEA to the physician will depend upon his knowledge of its nature and significance. CEA was first described by Gold and Freedman in 1965.1 It is characterized as a protein-

polysaccharide complex and is present in normal fetal tissues between two and six months' gestation.² After the sixth month in utero, the DNA of the fetal cells stops making CEA, ie, it is repressed.^{3,4} During malignant transformation in later life, this process is unlocked again - either by an event that triggers malignancy or one associated with it - and the cell recommences production of primitive components.⁵ This phenomenon is referred to as "depressive dedifferentiation."

Many groups have reported experiences with CEA similar to ours.²⁻⁴ Colon and pancreatic carcinomas seem to have the most highly elevated titers.^{6,7} In large studies, CEA titers are elevated in 90 percent of pancreatic tumors and in 80 percent of colorectal tumors.8,9 Other carcinomas with repeatedly elevated CEA levels are stomach, lung, and breast.8 Ovarian, head and neck, prostate, bladder, and cervical carcinomas show elevation to a lesser degree. 10 Nonmalignant conditions, such as gastrointestinal inflammatory diseases, liver disease, pancreatitis, and heavy smoking, also may be reflected in minimally elevated CEA levels.^{2,8,9}

An elevated CEA level in a patient with a highly suspicious history for carcinoma and an otherwise normal work-up should cause the physician to look more diligently for the possibility of an early occult neoplasm. Colonscopy might be an adjunct diagnostic procedure.11 Thus, the role of CEA diagnostically is that of an adjunctive tool. Postoperatively, it is helpful in assessing the current mode of treatment and in giving an indication of the completeness of the surgery (curative or not). Two case histories will demonstrate these points.

Case Reports

A 32-year-old white woman was admitted to The Ohio State University Hospital following delivery of a 3.6-kg (8-lb) infant two weeks prior to admission. At six months' gestation, the patient had developed extreme right lower-quadrant tenderness which subsequently became diffuse, necessitating ex-

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This investigation was supported in part by Public Health Service research grant CA-12287-04 from the National Cancer Institute, the Grand Chapter of Ohio Order of the Eastern Star, and the Grand Chapter of Phi Beta Psi Sorority.

Reprint requests to Department of Surgery, The Ohio State University Hospitals, 410 West Tenth Ave., Columbus, Ohio 43210 (Dr. Minton).

Submitted October 21, 1974.

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of Medicine.
Dr. Kibbey, Columbus, Surgical Resident and American Cancer Society Clinical Cancer Fellow, The Ohio State University Hospitals; and Clinical Instructor in Surgery, The Ohio State University College of Medicine.
Dr. Minton, Columbus, Cancer Coordinator, Clinical Division of Surgery, The Ohio State University Hospitals; and Associate Professor of Surgery, The Ohio State University College of Medicine.

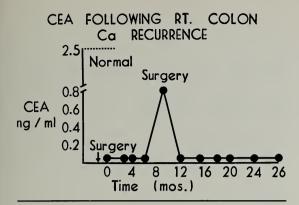


Fig. 1. CEA response to 2X2-cm intramuscular metastasis from a lesion of right colon, demonstrating sensitivity of the test.

ploration for an emergency appendectomy. At exploration, a large fungating tumor involving the right colon and cecum was found with perforation. Drains were inserted and the abdomen closed. During the remaining three months until term, the tumor grew onto the abdominal wall through the drain site. At this hospital, the entire mass was removed en bloc, requiring a right colectomy, right partial hepatic lobectomy, and excision of the abdominal wall involved with tumor. Pathologic diagnosis of the surgical specimen was adenocarcinoma. This patient was followed postoperatively with CEA determinations and close clinical examination. The first three CEA levels at monthly intervals were zero, and the CEA level at six months postoperative was also zero. At the nine-month postoperative examination, a small nodule was palpable in the incision and was thought to be a stitch abscess; however, the CEA level was elevated. A laparotomy was performed, and a small tumor nodule was removed from the incision site, with no cancer found within the abdomen. Subsequent CEA determinations at three-month intervals have remained normal, and at 24 months after surgery, the patient's health is excellent (Fig. 1).

Case 2. — A 55-year-old white man was referred because of two-months' weight loss and left lower-quadrant tenderness. The rectal examination revealed some tenderness, and the patient's stool showed a trace guaiac-positive. The barium enema was interpreted as consistent with diverticulitis, but malignancy could not be ruled out. The patient was treated with decompression, antibiotics, and intravenous fluids. He responded well, and repeat barium enema was read as a poorly prepared colon but probably consistent with resolving diverticulitis. In the meantime, a CEA level was reported as elevated (14 ng/ml). Repeat CEA determination, made while the patient was responding to treatment, was 15 ng/ml. Colonscopy was performed, and a small mass was found at the sigmoid flexure which was biopsied and interpreted as adenocarcinoma. Sigmoidectomy was performed, and confirmation of the biopsied adenocarcinoma was made. Subsequent CEA levels have been in the normal range at one-week, one-month, and three-month determinations. He is doing well and is back to work (Fig. 2).

These two cases are representative of many cases currently being followed with serial CEA's at The Ohio State University Hospitals. It is well established that CEA helps assess the adequacy of surgical resection, and that a value which returns toward zero indicates a favorable prognosis. The table shows the results of the work with CEA at

The Ohio State University Hospitals from September 1972 through July 1974.

Use of the CEA assay is currently being investigated in a number of areas, including evaluating chemotherapy; monitoring ulcerative colitis patients with CEA's and biopsies; following regional enteritis patients; following urinary-tract malignant tumors with urine and plasma CEA determinations; evaluating patients with primary and metastatic malignant breast tumors with CEA levels; and assessing the possible role of CEA in hepatic regeneration. Another area of interest is the correlation of CEA values with types of tumors, classified by a uniform staging system (T, N, M, type, grade, and symptoms). In the poorly differentiated grade III tumors, where the cells are too pleomorphic to make CEA, levels are predictably low.

Summary

CEA is *not* a screening test for carcinoma, but levels are highest in the presence of colon and

Results of Work with CEA at The Ohio State University Hospitals from September 1972 through July 1974.

	No. Tested	Elevated CEA					
Diagnosis	Testeu	No.	%				
Colorectal carcinoma (preop)	225	184	81%				
Gastrointestinal carcinoma (postop Carcinoma other digestive organs) 352	74	21%				
(preop) Nonmalignant diseases digestive	69	39	57%				
system	172	67	39%				
Nonenteric carcinoma, and others	178	54	30%				
Other nonmalignant conditions Total	104 1100	6	5%				

CASE#2 CEA FOLLOWING SIGMOIDECTOMY

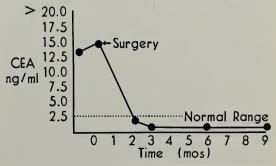


Fig. 2. CEA level in response to sigmoidectomy for carcinoma of sigmoid.

pancreatic tumors. It should never be used as a substitute for sound clinical judgment, rectal examination, sigmoidoscopy, and barium enema. However, if all other tests are normal but CEA is elevated, then this finding should challenge the physician to pursue the problem further or to explain this elevated CEA on another basis. Diagnostic colonscopy should be the next step. The physician who is familiar with this test and its limitations will find it a valuable tool in the diagnosis, prognosis, and follow-up of colorectal carcinoma.

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Benign Mixed Tumor of the Lacrimal Gland

A Case Report

James A. Lehman, Jr., M.D. Alfred L. Nicely, M.D. Nadhir Saddawi, M.D.

Extraocular tumors of the orbit are uncommon. It is reported that less than one half of these tumors are epithelial lesions. A patient with a benign mixed tumor of the lacrimal gland illustrating the problems in diagnosis and management is presented.

EXTRAOCULAR TUMORS of the orbit are uncommon. It is estimated that only one such lesion is found among 30,000 consecutive ophthalmic patients. Reese has reported that approximately one half of the tumors in the lacrimal fossa were nonepithelial lesions, mainly lymphomas and inflammatory pseudotumors. The most common benign tumor is the mixed tumor, and the most frequent malignant lesion is the cylindroma. The incidence of malignant lesions varied between 50 and 80 percent. The present case report illustrates some of the problems associated with the diagnosis and treatment of epithelial tumors of the lacrimal gland.

Case Report

A 78-year-old Negro man was admitted to a hospital on May 15, because of protrusion of the left eye which had become more pronounced over

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the last three months (Fig. 1). During the three weeks prior to admission, the proptosis had become pronounced and he had lost the vision in the eve. Examination revealed a nonpulsating exophthalmos of the left eye with exophthalmometer readings of 10 mm in the right eve and 23 mm in the left eye. Visual acuity was 20/40, O.D. and no light perception, O.S. The conjunctiva was injected, chemotic, and keratinized inferiorly. There was a mild exposure keratitis of the inferior cornea. The ocular movements were normal on the right but the left globe was immobile. No bruit was heard. The applanation tensions were 15 mm Hg in the right eye and 24 mm Hg in the left eye. Ophthalmoscopy revealed choroidal sclerosis in the right eye. In the left eye, there was a large indentation of the posterior fundus in the superior quadrant. There were choroidal folds in the left superior fundus and inferior nasal fundus. The optic disc was slightly pale and edematous. X-ray films of the skull and orbit showed a soft tissue density of the left orbit without definite bony involvement.

A biopsy of the lacrimal gland was performed. The histologic report was normal lacrimal



Fig. 1. Preoperative appearance of patient showing proptosis.

gland. Because of the tumor mass and the lack of vision in the eye, an exenteration of the orbit was planned. An exenteration was performed seven days following the original biopsy. A frozen section performed at the time of this surgery was reported as an undifferentiated malignant tumor. Because of this, the exenteration was extended to include the lateral orbital wall. The wound was resurfaced with a skin graft. Permanent sections of the tumor revealed a highly cellular, benign, mixed tumor (Fig. 2) without involvement of the surrounding tissues. One year later, the patient is doing well without evidence of recurrence (Fig. 3).

Discussion

Since approximately one half of the expanding lesions in the lacrimal fossa are nonepithelial, nonsurgical lesions, it is axiomatic that a definitive diagnosis must be established before the indicated therapy can be planned. A biopsy may be excisional or incisional, but excisional biopsy is preferred. In over one half of the cases, no further surgical treatment will be required. If an incisional biopsy is performed, adequate exposure is required to obtain a deep-wedge biopsy as frequently there is normal gland superficially. This point is well illustrated in this patient, and a second biopsy would have been required under normal circumstances. However, this patient was blind in the left eye and enucleation was the procedure of choice regardless of the pathologic findings.

Permanent histopathologic sections should be studied before proceeding with radical surgery. Frozen-section diagnoses in lacrimal gland tumors are difficult for an experienced pathologist to interpret and, as illustrated in this patient, an incorrect interpretation of a frozen section could lead to unwarranted radical surgery.

The treatment of benign lesions should be complete excision of the tumor without disrupting

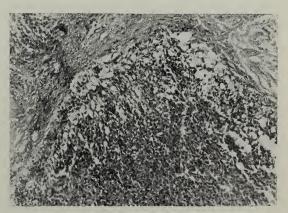


Fig. 2. Marked cellular appearance of tumor histologically.



Fig. 3. Postoperative appearance of patient one year after surgery.

the pseudocapsule. If the tumor is adherent to the periosteum, this should be stripped away from the bone and removed with the lesion. More radical procedures are unnecessary. Malignant tumors, however, require a radical exenteration including the lateral orbital wall.

Summary

A case report of a benign mixed tumor of the lacrimal gland has been presented. The problems associated with the diagnosis and treatment have been discussed.

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Detection of Amblyopia in Young Children

Gary L. Rogers, M.D. Morris L. Battles, M.D.

> A technique for detecting differences in the vision between the two eyes of young children by the use of fixation objects held at close range.

THE ABILITY TO DETECT differences in the 1 vision between the two eyes of a young child today has become a basic part of the examination of all ophthalmologists and many pediatricians and family physicians. In the very young, one must rely on objective signs, of which the most valuable is the ability to fixate and to continue to fixate an object of interest. In the child who has a strabismus, the presence or absence of movement of the formerly covered eye to take up fixation is easily observed. But this can be a more difficult task in the child whose eyes are straight. Just because the eyes appear straight, does not guarantee that amblyopia is not present.1

A target at close range can be used which coincides with the child's range of visual interest. The examiner then can make several small rapid movements of the hand-held fixation objects (Fig. 1) and can determine whether the following movements are smooth and prompt or searching and slow. This is more exacting than using a flashlight

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Reprint requests to 363 E. Town St., Columbus, Ohio 42000 (Dr. Barrel)

Ohio 43209 (Dr. Rogers). Submitted October 4, 1974.



Fig. 1. Determining fixation with near object.

and having the child attempt to fixate a light. Since the testing is done at close range, decreased visual acuity at distance from possible uncorrected myopia is avoided.

In the child with a strabismus, the return to fixation by one eye after its cover has been removed is evidence of a higher acuity in that eye, but the degree is not known. In the child with straight eyes, if evasive movements or actual pushing away of the occluder is repeatedly done, not because of mere



Fig. 2. Distance fixation device.

annoyance, the eye being required to fixate is usually at a severe disadvantage.2

The examiner can easily use the thumb of one hand over the child's eye without fear to the child and present the fixation target with the other hand. Many fixation devices are available today which employ the use of mechanically operated toys (Fig. 2), continuous reel projectors with cartoons for distance, and pictures, cards, and toys for nearvision testing.3 Once attention is gained, the examiner can secure the fixation by asking questions about the object presented, such as, does the dog have a carrot in his mouth, or a hat on his head.

After using such techniques, the fixation behavior can be characterized as good, central, and either maintained or not maintained, depending on whether fixation shifts back to the first uncovered eve. Poorer grades of fixation are described as no fixation, eccentric, or wandering. Although a grading of the exact acuity by this method is impossible, it definitely gives the ability to make a valid comparison between the two eyes and a strong indication of the presence of amblyopia.

The older child lends himself to more subjective testing methods of isolated "E's," picture cards, or the graded Snellen letters. A difference of two or more lines by this method can be indicative of an amblyopia and need of treatment.

Ideally, all children should receive an eye examination by the age of 2 or 3 years. This should include determination of the refractive error under cycloplegia. The findings of well-formed ocular structures and proper alignment is not an assurance against decreased visual acuity by a high refractive error in one or both eyes.

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Manuscripts Are Welcome

The Council of the Ohio State Medical Association believes that most of the 10,467 members of the Association have creative programs in health care delivery systems which they might profitably share with their colleagues. The editorial staff would be pleased to receive articles on health care delivery systems, on medical socioeconomic questions, and on legislative programs-local, state, and national-involving patient care and health services.—R.L.M.

Ohio Public Health

John H. Ackerman, M.D., M.P.H.

Our immunization Unit will assist Marion County physicians and volunteers in conducting an immunization program for pre-school children during May and June.

A group of physicians in a local clinic found that 68 percent of the two-year-olds seen by them during a seven month period were inadequately protected against polio. As a result, a "Sabin on Sunday" type program was organized with clinics to be conducted at five locations on the Sundays of May 4th and June 8th. The program has been endorsed by the Marion County Medical Society.

If parents respond and bring their children, they won't have to worry about school entrance requirements for polio immunization. We found 3,641 children in the Cleveland school system who did not meet the school entrance requirements. Proper steps have been taken and now all are protected with poliomyelitis, measles and rubella vaccine, as needed. Cleveland is in good shape.

One of the members of our staff was in the limelight last month when he gave a report at a meeting of the New York Academy of Sciences. The results of an investigation by Peter F. Infante, D.D.S., Dr.P.H., indicated that residents of three Ohio communities with polyvinyl chloride production facilities gave birth to a significantly greater proportion of children with malformations during the four-year period of 1970 to 1973 than the average for the remainder of the state. He also found there was a higher incidence of certain cancers among adults in these communities.

A \$31,588.00 Emergency Medical Services grant has been awarded to Paulding County for the purchase of two ambulances and radio communications equipment. The two ambulances will be operated by the volunteer fire department at Paulding and Oakwood. With the arrival of this equipment, Paulding will now have complete emergency ambulance service for the 19,000 citizens of the 417 square-mile area. The Emergency Medical Service Program is funded by the U.S. Department of Transportation and administered by the Ohio Department of Health.

The Department conducted four public reviews last month on proposed health service areas as required by the National Health Planning and Resources Development Act of 1974 (Public Law 93-641). The meetings were in Lima, Cincinnati, Marietta and Akron.



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Overdosage may cause a curare-like action, with loss of voluntary muscle control. For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted. Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthine.

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Overdosage should be avoided in patients severely ill with ulcerative colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

Dosage and Administration: The recommended daily dosage for adult oral therapy is one 15-mg, tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

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Comments

To Strike Or Not To Strike? Is This Really The Question Facing Our Profession?

It is difficult to assess why the "upper echelon at 525 N. Dearborn" issued a statement on March 18 which was interpreted by the media, the strikers, and the AMA staff as supporting the New York City strike—the first major strike ever undertaken by American physicians. Was the statement a response to that time-worn remark about "the dues paying members of tomorrow"?

I humbly ask: "Where was AMA's support of the physicians who continued to care for patients in the 21 metropolitan New York hospitals during the strike? In my opinion, these interns, residents, full-time and volunteer staff physicians deserve the support and commendation of all medical colleagues. These are the physicians who served their fellow man. Thanks to their efforts, even the critical media reported no deterioration in the medical care of the hospitalized patients care during the unwarranted and unnecessary four-day strike.

During the strike, rather vague statements were issued about interns and residents serving 80 to 100 hours of continuous duty each week. Three to four successive nights of duty was another issue. Yet according to statements in *The New York Times*, the side issue was "resident moonlighting." The strikers wanted the opportunity to "moonlight" in non-teaching hospitals and clinical facilities while receiving full credit for educational experiences in the teaching hospital. *The New York Times* reported the strikers could earn \$1,000 per weekend if they were relieved of their hospital responsibilities. I fear the issue of "improved patient care" was only a facade to hide the issue of "moonlighting."

The strikers (approximately 2000) are said to be only a minority group of the "Committee of Interns and Residents," union, if you will. Since they announced the strike several weeks before walking out (on their patients) March 17, the group sought and received ample press, television, and other media coverage. In fact, the coverage brought to mind the campus activities prevalent when these strikers were undergraduates. I am referring to the militant individuals called "activists" who threw rocks at university buildings and police while proclaiming their dedication to peace.

The strikers did not suggest improving academic programs or establishing an independent study program to reduce the "calendar month" requirements of the archaic specialty board prerequisites.

I would be the first to agree that post-MD education in the United States needs adequate and comprehensive study review, and reorientation. Effective programs designed to meet our goals and society's needs must be established. There is a lack of scientific evidence supporting the value of "primary-type" educational programs now demanded of post graduate medical students (24, 36, 48 or 60 months of residency training.) It is time to critically examine these programs to determine if they are truly educational in their present format.

However, strikes will not solve educational problems. Not even when they are blessed by "535 N. Dearborn." Leadership, not permissiveness, is needed as a credo for our profession.

Concerning the strikers (only 4 out of 450 at one hospital), should we accept them in responsible positions of trust in patient care programs or future medical organizational programs. This is the question which their peers must seek to answer in the immediate future for it involves the welfare of patients as well as the profession.

-Richard L. Meiling, M.D.

Ohio State Evaluates Independent Study; Finds These Students Score Higher

In the 1960's, several faculty members of Ohio State's College of Medicine stimulated their colleagues to study and restructure the curriculum leading to the "Doctor of Medicine" degree. Leaders among the group included former Dean John Prior, M.D.; former Associate Dean Lloyd Evans, M.D.; and the late Chairman and Professor of Anatomy, Grant Graves, M.D. These pioneers were

followed by Associate Professor of Medicine, Robert L. Folk, M.D.; Professor of Preventive Medicine, Martin Kellar, M.D.; Assistant Dean, Gregory Trzebiatowsky, Ph.D.; and present Director of the Independent Study Program, Robert L. Beran, Ph.D.

Comparative studies of students entering in (Continued on Next Page)

Comments / continued

1970, 1971 and 1972 showed that those pursuing independent study programs scored higher in anatomy, physiology, and biochemistry than those pursuing the lecture-discussion program. (This is according to material recently published by the Association of American Medical Colleges.)

These findings substantiate the preliminary reports of Dr. Folk in 1973. He stated that observations indicated Independent Study Program students scored higher in such Medical School Environment Inventory involving (1) breadth of interest (2) attitudes toward the faculty (3) encapsulated training and (4) intrinsic motivation.

A complete report of Ohio State's College of Medicine program will be released soon by the publisher: Educational Products, Inc. of Oak Brook, Illinois. In the meantime, seven medical faculties in the United States, as well as medical faculties in South America, Europe and Asia are utilizing both the Independent Study Programs and Computer Assisted Instruction Program pioneered by Ohio State's College of Medicine.

More than eight years of faculty study, review, and reorientation were involved before Ohio State introduced the "reoriented medical curriculum," "computer assisted instruction," and "independent

study programs."

However, the response of students and the recognition received from national organizations concerning this pioneering leadership is a worthy reward for all concerned the time and effort expended in this academic program.

-Richard L. Meiling, M.D.

Biting Insect Summary

Again, this year I am compiling a Biting Insect Summary and would appreciate any case reports of unusual allergic reactions to biting insects, i.e. mosquitoes, fleas, gnats, kissing bugs, bedbugs, chiggers, black flies, horseflies, sandflies, deerflies, etc.

I would like physicians to supply me with case reports of those patients who have had unusual reactions to such insects. Include in your reports, the type of reactions and complications, if any, the age, sex, and race of the patient, the site of the bite(s), the season of the year, the immediate symptoms, the skin test results, desensitization results, if any, and any associated other allergies. Please send this information to the following address:

Claude A. Frazier, M.D.

4-C Doctors Park Asheville, N.C. 28801.

Thank you for your assistance.

-Claude A. Frazier, M.D.

Antihemophilic Factor

On December 17, 1973, a State Program for Hemophilia came into being, under the Director of Health. Of course, care for persons suffering from hemophilia began many years before. Blood banks, as sources of clotting factor replacement, have been instrumental in the improved therapy of hemophilia.

Classical hemophilia involving Factor VIII deficiency is generally the most severe. Several years ago, Dr. Judith Pool developed cryoprecipitate, which contains concentrated Factor VIII and fibrinogen. Cryoprecipitate can be manufactured in a Blood Center from the fresh plasma of normal donors. Because of its relatively simple manufacturing processes, cryoprecipitate is termed a component. Red Blood Cells, sometimes called Packed Red Cells, are another product of the preparation of cryoprecipitate. Source plasma is also a product and can be processed into serum albumin, plasma protein fraction or immune serum globulin by pharmaceutical manufacturers. Products made by pharmaceutical manufacturers are termed derivatives.

Dry Antihemophilic Factor (AHF) Concentrate is a derivative produced from fresh frozen plasma. Blood Centers in Ohio are actively harvesting a great deal of fresh frozen plasma for processing either into cryoprecipitate (component) or Antihemophilic Factor Concentrate (derivative). A by-product of either process is Red Blood Cells. As Blood Centers increase their production of Antihemophilic Factor, the production of Red Blood Cells also increases.

The increased availability of Red Blood Cells rather than Whole Blood does not pose a hardship for the patient. Many studies have shown the majority (75-90%) of patients need only the red cells. The body quickly replaces lost plasma from the large extravascular pool of electrolytes and proteins. Only the bone marrow responds slowly, necessitating red cell, white cell or platelet replacement when loss is greater than production. Even so, the body compensates remarkably well to red cell losses with increased 2,3 DPG and increased oxygen carrying capacity.

Volume depletion, not cellular reduction, gets the patient into difficulty with rapid blood loss. The Vietnam experience showed better survival with fluid and red cell replacement than blood replacement alone.

The Hemophilia Program is encouraging Blood Centers to produce sufficient Antihemophilic Factor for the needs of Ohio residents.

-Melanie Kennedy, M.D.

Physicians Cannot Practice Without Adequate Insurance

In response to continuous inquiries by reporters, Dr. James L. Henry, OSMA President, issued the following press release on April 10.

"The situation which recently forced seven Mansfield anesthesiologists to halt their practice of medicine serves to focus attention on the serious implications surrounding the unavailability of medical malpractice insurance. The action taken by the Mansfield physicians is not a strike, but rather the inability of physicians to practice medicine without adequate malpractice insurance coverage.

OSMA supports the right of the private physician to choose, not only where to practice medicine, but also under what conditions he will practice in order to provide the best possible professional services to his patients. However, without malpractice insurance, the physician cannot be expected to practice medicine. OSMA is concerned that the people of Ohio may not be able to receive adequate medical care in the near future.

OSMA is doing everything possible to obtain malpractice insurance for the Mansfield physicians and to assure the availability of insurance for all Ohio physicians. Without this coverage, interruption of medical care delivery in Ohio is a very real possibility."

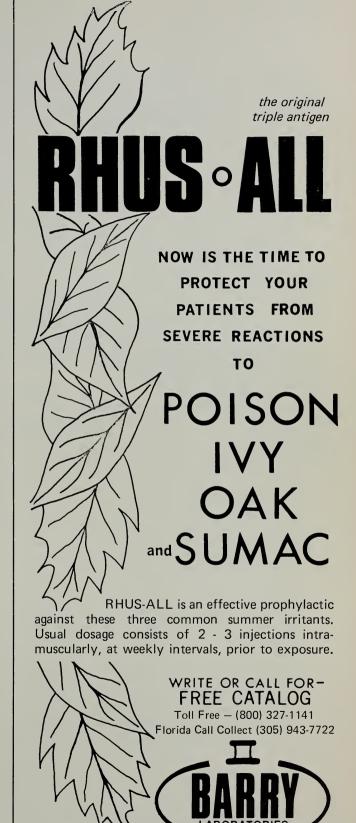
OHIO DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Division of Mental Health

Mental Health Superintendent—The position of superintendent at Cambridge State Hospital will become vacant effective July, 1975. A Search Committee is now accepting letters of application for this position. We are seeking a professional who wishes to participate in the development of a mental health delivery system fully coordinated with community-based services.

All inquiries confidential An Equal Opportunity Employer Letters of application or inquiry should be sent to:

Ms. Anne Cope, Staff Assistant Search Committee District 9 Office Division of Mental Health Cambridge State Hospital Cambridge, Ohio 43725



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Scene



National Health Insurance This Year?

When asked about National Health Insurance, Dan Rostenkowski, House Ways and Means Committee, Health Subcommittee Chairman, is not one of those Washington sources who say: "Not this year."

The Illinois Democrat has announced that he plans to have a bill establishing a national health care system on the floor of the Congress by September. The Congressman called his subcommittee into a bill-writing session in April, after appointing a national advisory group to advise his subcommittee about the contents of the legislation.

In January, Mr. Rostenkowski announced that his subcommittee would not hold public hearings on the subject, in view of the thousands of pages of testimony heard last year by the Ways and Means Committee. He elected to follow his own game plan in lieu of the public hearings route.

One obstacle a Health Subcommittee bill may encounter is a jurisdictional fight over the issue. Congressman Paul Rogers, chairman of the Subcommittee on Public Health and Environment, Committee on Interstate and Foreign Commerce, is attempting to claim jurisdictional rights for his committee. The Florida Democrat has a long history of sponsoring health legislation, including last year's National Health Services and Facilities Act, and his unsuccessful National Health Manpower Act, a bill which he has reintroduced this year and his Subcommittee has recommended for passage.

Tuesdays At The White House

To open a dialogue between major non-governmental organizations and the Executive Office, weekly Tuesday morning programs have been started by Theodore C. Marrs, M.D., Special Assistant to President Ford and a board-certified pediatrician. The programs focus on domestic problems confronting both the electorate and the elected. Topics, which vary each week, have included areas such as education, ethnic community programs, bilingual education, and nursing homes. Press coverage is not permitted.

On April 1, the "Tuesday at the White House" session was concerned with the malpractice crisis. Attending were leaders in the labor movement, state insurance directors, insurance industry executives, the American Medical Association's President, American Hospital Association executives, and the Secretary of the Department of Health, Education, and Welfare.

All present were vitally concerned with the cost and limited availability of professional medical liability insurance in the United States. The labor organization leaders apparently now recognize that astronomic insurance premiums, attorneys' contingency fees, and unjustified claims filed against hospitals, physicians, surgeons, and dentists will be a direct "pass-through" to the consumer. So will judgments when rendered. No longer can consumers, legislators, or others afford to say "doctors had it coming" or "it's the doctors' own fault" since they realize who must pay the bill for increased medical care costs.

Legislative solutions are not always wise or equitable. However, only a legislative answer will now solve the malpractice crisis. The only question remaining is: "How much freedom must we sacrifice to maintain a medical and health delivery system?" Consumers, patients, labor negotiators, insurance executives, hospitals, clinics, physicians, surgeons, dentists, pre-M.D. and post-M.D. students, allied health personnel, and educators are all involved in working out the answer to this question.



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'Claims-Made' Policies May Be Insurance Carriers' Reaction To Malpractice Crisis

What is the difference between the 'occurrence' policy you probably have now and the 'claims-made' policy you may have in the near future?

Within the next few months, many Ohio physicians will be without professional liability insurance, either because premiums are unreasonably high or because malpractice insurance is just plain unavailable. Many insurance companies have announced they will soon discontinue writing malpractice insurance. Others will continue to renew existing policies but will take few, if any, new accounts. Still others are beginning to experiment with a different type of policy in an effort to stay in the professional liability business.

Currently, most insurance companies offer what is known as "occurrence policies." Under the occurrence system, a physician is protected for all incidents which occur during the time the policy is in force, regardless of when the claim was made. For example, Dr. A. carries an occurrence policy from 1970 through 1974. He cancels the policy in 1975. In 1976, a suit is filed against him for an incident which occurred in 1972. Although he no longer carries the policy, he is still covered for any incident which occurred during the time the policy was in force, thus he is covered for the 1972 incident.

Premium rates under the occurrence system are paid during the policy year and based on projected costs five years or more in the future. Projected costs include anticipated rates of inflation, number of malpractice suits filed and costs of settling claims.

Recently, a few insurance companies announced plans to experiment with a different type of policy, known as "claims-made." Under the claims-made system, the policy will cover claims made, that is reported or filed, during the year the

policy is in force, for all incidents occurring that year. For example, Dr. A carries a claims-made policy during 1974. He cancels in 1975. In 1976, a suit is filed against him for an incident which occurred in 1974. Since he no longer carries a claims-made policy, he will not be covered for the 1974 incident.

Rates for claims-made policies are based on the past pattern of actual claims reported and their costs, plus a 12-month projection of the current policy year, rather than on projections of five years or more.

The physician pays his first year's premium based on these projections and is covered for all suits filed against him for incidents occurring that year only. The second year, he pays a premium based on the same projections, but is covered for all suits filed against him for incidents occurring during that year and the first year. The third year he pays a premium based on the same projections and is covered for all suits filed against him for incidents occurring that year and the two previous years, and so on.

Since most medical injuries are discovered three to five years after they occur, a physician will pay his highest premiums after the third year.

The advantages of the claims-made policy are:

• Availability — In theory, claims-made should allow for better justification of rate increases, since rates will be determined on the basis of known data and a 12-month projection, rather than five or more years. This will allow insurance companies to set rates more accurately and thus stay in the malpractice business.

• Regulation — Since rates will be based on known data and only a one year projection, the Ohio Department of Insurance will be able to more easily ascertain whether or not a rate increase request is justified.

• Cost — The cost for claims-made policies will be lower in the short-run, thus making it easier for new physicians their first few years of practice. However, costs in the long run could be higher than they would be with an occurrence policy.

The disadvantages of claims-made occur, for the most part, when a physician dies, becomes disabled, retires, moves to a different state, or

changes insurance companies.

Before buying a claims-made policy the physician must be absolutely certain that he has the option of what is known in the insurance trade as "buying up the tail." This is an option which states that all claims made against you after you die, become disabled, retire, move to a different state or change insurance companies, will be covered under the claims-made policy. In other words, a claims-made policy will not cover any claims filed against you after cancellation of the policy, even though the injury occurred during the time the policy was in force.

For example, Dr. B retires in 1975. He has carried a claims-made type insurance policy for the last five years. It is cancelled when he retires. In 1976, a suit is filed against him for an injury which occurred in 1974. If he has not bought up the tail, that is, bought the option in the insurance policy which guarantees to cover all suits filed against him

after he retires for all incidents which occurred while he was covered under the claims-made insurance system, he is without coverage for the

The same situation could occur when a physician decides to leave the state to practice elsewhere. Prior to moving he must be certain he has bought the option which will guarantee him adequate coverage in the event a suit is filed against him for an incident which occurred while he was still in Ohio. It is unlikely that an insurance company in another state would cover claims made prior to the starting date of the new policy it issued, mainly because of the differences which exist in the insurance regulations among many states.

A second disadvantage could occur as the result of possible abuses of claims-made when the physician decides to buy up the tail. For example, Dr. C decides to cancel his policy with Company X and go with Company Y. Company X could lock Dr. C into staying with their company by charging a very high rate to buy up the tail. Dr. C, not being able to afford the high cost of buying up the tail, is forced to stay with Company X, even though Company Y might be able to offer him a better policy. It is the responsibility of the Ohio Department of Insurance, however, to assure that these kinds of abuses do not occur.

Claims-made will not solve the malpractice insurance problem, but it may improve the availability of insurance now, when it is needed most.

-Rebecca J. Doll

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The **Professional** Liability Crisis

OSMA Headquarters is continually working to find solutions for the professional liability crisis facing Ohio physicians. Last month's Journal contained a special report from James L. Henry, M.D., OSMA's President, describing OSMA's investigation and action program. In this issue, the proposed professional liability bill currently before

Ohio legislators will be analyzed.

The proposed "Medical Malpractice Insurance Bill" (HB . . .) is the joint result of extensive negotiations between Harry Jump, State Director of Insurance, and several interest groups: Ohio State Medical Association, Ohio Bar Association, Ohio Hospital Association, Ohio Osteopathic Association, and various insurance carriers who write professional liability insurance in the State of Ohio. The proposed bill appears to be the best piece of legislation that each of these special interest parties can agree upon. It is a constitutional and fair approach to resolving the current crisis situation and will hopefully reduce the overall cost of medical care for patients.

Have you contacted your legislator and state senator concerning the professional liability crisis? Let them know there is an urgent need for this bill, and how it will serve the people of Ohio. Your local Auxiliary members can also be extremely helpful in contacting legislators and senators.

In reading the detailed analysis of HB which follows, you may wish to use the index list of "Ohio Revised Code" sections to find particular portions of the bill.

Index

Arbitration Statute, Amendment to	2711.01	
Arbitration in Court of Claims,		
Enactment of	2743.45	
Collateral Source Rule, Amendment to	2743.02	
Contingent Fee, Regulation of	2743.43	
Court of Claims, Amendment to	2743.01 et a	al
Expert Testimony, Requirement of	2743.44	
Frauds Statute, Amendment to	1335.05	
Informed Consent, Enactment of	2743.42	
Joint Underwriting Authority,		
Enactment of	3937.13	
Liability Immunity For Peer Review,		
Amendment to		
Medical Practice Act, Amendment to		al
Patient Records Statute, Amendment to		
Peer Review Records, Protection of	2305.251	
Prayer Clause (Ad Damnum),		
Amendment to	2743.131	

Proposed Medical Malpractice Insurance Bill

Sec. 1335.05. Changes the provisions of the Ohio Statute of Frauds to provide that no patient may sue a physician for any oral promise that might have been made regarding the patient's prognosis. In order to claim a breach of the contract to treat and provide specific results, the patient must produce a written document outlining the promise or agreement which the physician has failed to meet.

Sec. 2305.25. Limits the liability of members or

employees of utilization review committees, tissue committees or peer review committees for actions taken in good faith as a member or employee of that committee. This section also adds language to permit any member or employee of a hospital board or committee to have this

limited liability

Sec. 2505.251. Provides that the findings and data of a utilization review committee, tissue committee or peer review committee may not be used against a physician or hospital in a civil case. The purpose of this section is to protect the confidentiality of peer review mechanisms.

Sec. 2317.02. Amends the current laws relating to the confidentiality of the patient/physician relationship. When a patient brings a malpractice action against a physician or hospital, records will be as accessible to the defense attorney as they are now to the plaintiff's at-

Sec. 2711.01. Makes a small change in the Ohio Arbitration Statutes so that agreements may be made voluntarily by patients to provide for binding arbitration if a disagreement might arise. The current statute only provides for an agreement to go to binding arbitration in existing problem areas and this provision would permit binding arbitration for problems that might arise after the

binding arbitration for problems that might arise after the signing of the document.

Sec. 2743.01 et. seq. Amends the Ohio Court of Claims Statutes to provide that the Court of Claims shall have original jurisdiction in all cases involving civil actions against hospitals and physicians in which a medical claim is asserted. The Ohio Court of Claims was established last year to provide a mechanism for citizens of the State of Ohio to sue the State in lieu of sovereign immunity, which the State of Ohio at that time waived.

Using the Court of Claims as the entry point for all medical professional liability suits will enable the State of Ohio to establish a central forum for all such actions and will allow the judges of this Court to become knowl-

and will allow the judges of this Court to become knowledgeable in this extremely complex and sensitive area. The Court of Claims will continue to utilize the current jury system, but the Court will become much more knowledgeable concerning medical and surgical procedures.

(Continued on Next Page)

Within Chapter 2743, which controls the Ohio Court of Claims, the omnibus bill makes a number of other additions. These include:

Sec. 2743.02. Eliminates the immunity of governmentally operated hospitals and requires them to fall within the jurisdiction of the Court of Claims. It also must be reduced by the aggregate of any monies the plaintiff has already received from insurance, disability awards or any other collateral source.

Sec. 2743.03. Establishes a Court of Conciliation within the Court of Claims which shall operate under the

Court of Claims judges and which shall attempt to settle all cases for medical malpractice brought before it by either mediation, conciliation or arbitration. The purpose for this Division of Conciliation is to attempt to find common areas of agreement between parties before going to full court action. Where arbitration is voluntarily chosen by both parties, it will be binding. Where arbitration is not chosen and where settlement is not reached by conciliation, the full Court of Claims shall be utilized to reconcile the suit.
Sec. 2743.04. Provides that judges of the Court of

Claims and the Division of Conciliation shall be compensated for necessary travel expenses by the State.

Sec. 2743.10. Provides that upon written request, medical claims for less \$1,000 may be determined administratively by the clerk of the Court of Claims.

Sec. 2743.11. Deals with hospitals operated by governmental agencies and adds them to the current system.

tem involving suits against the State in the Court of

Sec. 2743.12. Provides that copies of the findings of the Court shall be certified to the defendant hospital

or physician.
Sec. 2743.13. Establishes procedures for notifying and issuing summonses under the Court of Claims.
Sec. 2743.131. Establishes the complaint procedure

for medical claims and adds a provision that the amount of damages shall not be stated in the initial complaint

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although the party against whom the action is being sought may at anytime request a statement setting forth the amount of damages being requested. In any event, the amount of the requested damage must be filed by the plaintiff at least 60 days prior to the date set for trial.

Sec. 2743.14. Provides that in medical claims before the Court of Claims, the defendant's insurance company shall investigate and defend instead of the Ohio Attorney-General. The Attorney-General will still defend

cases against the State.

Sec. 2743.161. Changes the statute of limitation relating to hospitals, both governmental and nongovernmental, to bring them into conformity with the statute of limitation currently being imposed upon claims brought

against physicians for medical malpractice.

Sec. 2743.191. Allows judgments rendered by the Court of Claims on medical claims to be rendered in the same manner as judgments would normally be rendered in a Court of Common Pleas.

Sec. 2743.41. Permits hospitals to purchase professional liability insurance. In some instances, hospitals which are operated by governmental entities are today not permitted to purchase such insurance. This bill would allow them to do so.

Sec. 2743.42. Establishes an extensive written informed consent form for the use of all hospital admissions. This consent form is specifically delineated within this section and requires the physician to outline with the patient most problems which might arise out of any pro-

cedure about to be undertaken.
Sec. 2743.43. Establishes a sliding scale for contingent fees which may be paid to the plaintiff's attorney.

The schedule is as follows: 50% on the first \$1,000 40% on the next \$2,000 33½% on the next \$47,000 20% on the next \$50,000 10% on any over \$100,000

Sec. 2743.44 Requires expert medical testimony to be presented to prove the physician deviated from the accepted standard of care in the specific circumstances of the case. Accepted standard of care is defined as being the degree of knowledge and degree of care ordinarily exercised by a physician practicing in the same specialty in a same or similar community to that in which the defendant practices. Sec. 2743.45. States that a judgment may be en-

tered in the case of voluntary binding arbitration by the Division of Conciliation and makes such judgment en-

forceable.

Sec. 3937.13. Establishes a joint underwriting authority with the Ohio Department of Insurance to provide medical professional liability insurance to any individual or hospital who is entitled to such insurance but who has been unable to find acceptable policies through ordinary methods. This plan will require that all instrance companies authorized to issue liability policies in this State shall contribute to the plan and shall be assessed, if necessary, to compensate for any losses the plan might incur. The Department of Insurance under this plan will issue policies to hospitals and physicians including interns and residents. The plan shall be operated by a governing board and this governing board shall have representation from the Ohio State Medical Association and the Ohio Hospital Association as well as from the various liability underwriters in the State of Ohio.

This joint underwriting authority shall operate from the time of passage of this bill until December 31, 1978.

Sec. 4731.01 et seq. Constitutes a major revision of the Ohio Medical Practices Act, the laws under which physicians and most other health care providers are licensed in the State of Ohio. The provisions of this part of the bill are as follower.

of the bill are as follows:

Sec. 4731.01. Retains the existing language for terms of office of the seven M.D. members and increases to seven years the term of office of the D.O. member of the State Medical Board.

Sec. 4731.02. Permits the secretary of the State Medical Board to be a member of the Board.

Sec. 4731.03. Existing language.

Sec. 4731.04. Explicity denotes powers and the responsibilities of the State Medical Board under (A) and (B). This is a replacement of 4731.20 in the present law.

Sec. 4731.05. Lists the powers and responsibilities of the Board with regard to the individual licensees. It also explains the power of the Board to investigate incidents and evidence presented to it relating to all medical practitioners licensed under Chapter 4731. The purpose of 4731.05 is to set guidelines that will sustain a post proceeding court test. When a license is revoked on the basis of evidence and hearing presented to the State Medical Board, the court will sustain the Board on appeal. Presently, the necessity of proving gross immorality or grossly unprofessional conduct makes appeals to the courts an easy way of getting licenses reinstated. It is the intent of this statutory language to make a license difficult to recover if it has been revoked under 4731.05. The proving by a preponderance of evidence of a violation of one of these sections in (B) should be enough to sustain the revocation of a license in a subsequent court hearing. We list 16 reasons why the license may be removed.

(B) (15) gives the Board the authority to require medical and mental examinations of licensees and the power to revoke a license on the basis of information that is presented to the Board subsequent to the mental or physical examination. This section also requires the State Medical Board to undertake supervision of a program of rehabilitation for those licensees that the Board has suspended, placed on probation or revoked their certificates if there is reason to believe that they can be

rehabilitated.

4731.05 (C) creates a responsibility on the Board to investigate evidence presented to the Board, grants immunity to any one presenting evidence to the Board to investigate and pursue the evidence presented to it.

Sec. 4731.06. Present language.
Sec. 4731.07. (B)(2) has been changed to read: the applicant attained on a qualifying examination a score acceptable to the State Medical Board. This change was recommended by Dr. Cramblett and members of the State Medical Board.

The bill deletes the requirement of depositing a The bill deletes the requirement of depositing a certificate with the probate judge. All responsibilities of a probate judge in relation to certificates filed by physicians and limited practitioners have been deleted at the recommendation of the State Medical Board. These are currently 4731.25, 4731.26 and 4731.27.

Sec. 4731.12. Registration is changed from bianual for M.D.'s and annual for D.O.'s to triannual and for the M.D. there will be a continuity and included in the contraction.

for the M.D. there will be a continuing medical education requirement of 150 hours. The D.O. education requirement has changed from two days per year to 150 hours every three years. The D.O. change was recommended by Dr. Timmins of the State Medical Board.

Sec. 4731.13. Is the ability to grant licenses without examination for those licensed in another state or Canada, if the applicant met the similar requirements in the other place where he received his license.

The new draft deletes the limited certificate at recommendation of the State Medical Board

Sec. 4731.14. Is a compilation of existing sections regarding the practice of medicine and the holding oneself

out as practicing medicine. However, enforcements have been removed from this section to 4731.05 and 4731.99.

Sec. 4731.16. Begins the podiatric medicine section. Language is identical to existing law except that the requirement of filing the certificate with probate court is deleted and the separate violations of ethics have been included under 4731.04 rather than in the separate

Sec. 4731.27. Begins the physical therapy section.

The physical therapy section is the same as present law. Sec. 4731.35. Begins the nurse-midwife section. Changes have been made to this section at the recommendation of the American College of Nurse-Midwives by changing the name to nurse-midwifery rather than midwifery and by defining nurse-midwife and by creating a committee of nurse-midwives to be set up by the American College of Nurse-Midwives to help the State Medical Board license nurse-midwives.

Sec. 4731.43. Is the beginning of the limited practitioners sections is a revising presently of 4731.15 and 4731.16. 4731.15 lists all the present limited practitioners that are licensed by the Board and this list has been eliminated. The only limited practitioners remaining are chiropractors, mechanotherapists, cosmetic therapists and practitioners of massage. The following sections define their practice and their educational requirements as they are presently defined under State Medical Board rule. This statutory definition and requirements of education and other requirements is an attempt by the Ohio State Medical Association to identify and define the limited practitioners in such a way that their scope of practice is evidence. dent to both limited practitioners and the members of the public. Each of the four subsections are similar for chiropractors mechanotherapists, cosmetic therapists and practitioners of massage. These sections permit the State Medical Board (as does the present law) to have one member of each limited profession help devise the test for that limited profession and to advise the Board on procedures and new educational information that is available regarding the practice of their limited practices. The requirement that their certificates be deposited with the probate judge has been eliminated as is the case with all other practitioners under 4731.
Sec. 4731.65. Present law regarding nurse anesthe-

siologists. No change.
Sec. 4731.66. Present law.
Sec. 4731.67. Present law regarding abortion.

Sec. 4731.68. Present law.

Sec. 4731.98. Present law.
Sec. 4731.99. Present law, except that the sections have been changed to reorganize the offenses so that they are similar to existing offenses. We think that the penalties are in accordance with present statutory intent under present 4731

In addition, this bill increases fees in accordance with recommendations from the State Medical Board. For example, the M.D. will pay \$50 every three years rather than the present \$10 every two years for reregistration.

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Legal Implications Of Generic Drug Substitution

John B. Chewning, M.D., J.D.*

Pharmacists exercise their dispensing responsibilities based on scientific and professional principles and knowledge of the prescription as ordered by the prescribing health professional. The prescriber exercises his responsibility to the patient based on scientific and professional principles and knowledge of the pharmacologic activity of the drug ordered.

It is not important who is possessed of equal or superior knowledge about the drug product composition and action. The real issue is who, the pharmacist or the prescribing professional, has the greater knowledge of the patient—the patient's past medical history, present medical condition and therapeutic plan, short or long-range. Reduced to this single simple question—what is best for the patient?—there then arises a medical and a legal doubt about any legislative act which would permit any person but the prescriber to change that prescription one iota.

The treating physician in his relationship with the patient (and frequently involving members of the patient's family or a spouse) is required to render his medical skill and knowledge by standards of professional conduct and by law. Today. medicine is practiced within a complex structure of interdependent co-professionals and paraprofessionals. Each, through the treating physician or directly, owes a duty to the patient. The breach of this duty with proximal harm to the patient gives the injured person, and ofter others connected with the injured person, a right to sue for legal relief.

The patient relies, as he should, upon the judgment of his physician. Lawmakers should not confer upon persons other than the treating physician a protected status to make a unilateral therapeutic or diagnostic decision, such as to change a nursing procedure, a laboratory test, or other order by the patient's physician. It is the physician who

examined the patient and made the diagnosis. Legislatures in a few states have made it legal for a pharmacist to substitute another drug product for the one prescribed by the physician. To empower the pharmacist to substitute a "generic" or

*Dr. Chewning is a member of OSMA's Committee on Pharmacy. He is also Director of Public Af-fairs for Merrell-National Laboratories, Cincinnati.

an "equivalent" brand named product for the prescribed drug in effect makes the pharmacist a subrogate physician.

A Hypothetical Case

Assume the physician explains to a patient all material risks and consequences of the proposed therapy so the reasonably prudent patient may make an informed objective decision to accept or reject the proprosed treatment.1

Assume further, as part of the explanation given to the patient, the physician explains the risk to benefit information about a pharmaceutical, a brand name known as X, and writes a prescription for X. The patient² accepts the physician as his agent possessed with superior knowledge to select this particular drug as part of the treatment plan and takes the prescription to a pharmacy. This is one manifestation of his consent to treatment.

Next, in the chain of assumptions regarding a hypothetical prescription, several events could occur:

- 1. Drug X¹ is substituted by a pharmacist without the patient's knowledge from a formulary list of "equivalent" drugs. An adverse reaction occurs. The patient thought he was to get X not X1 and his informed consent did not extend beyond X, a brand name of a specified manufacturer, or
- 2. Drug X¹ is substituted by a pharmacist who informs the patient X1 is the "same as X" because a) he doesn't have X in stock or b) X¹ is cheaper anyway. The patient, thus informed, accepts the pharmacist's recommendation and consents to the substitution. A serious reaction attributed to X^1 results,
- 3. Drug X¹ is substituted only after the patient says to the pharmacist, "Don't you have anything cheaper but just as good?" The pharmacist dispenses X1 without informing the prescribing practitioner. A complication allegedly results from use of X1 in this

Other hypothetical fact situations could be constructed to focus on the potential difficulties which could result and, in one way or another,

affect the legal duties and legal rights of the pa-

tient, physician and pharmacist triad.

These three hypothetical substitution problems illustrate how legal liability could shift among potential defendants. Liability may not be limited to the physician and pharmacist but also it could possibly include the formulary committee and/or the hospital, if solely controlling the pharmacy.

The hazards of generic prescribing in terms of professional liability risk to the physician have been analyzed elsewhere by Morris³ who wrote: "... the physician who prescribes by generic name, rather than by brand name, thereby increases his medical malpractice exposure unless he undertakes the additional burden of (1) informing himself of the contents of all medical literature concerning all drugs that a pharmacist may properly choose to use to fill the generic prescription, and (2) taking from the patient, prior to therapy, an informed consent based upon disclosure of all risks reported in all such literature for all such generic equivalents."

The pharmacist has a place as an advisor in therapy, a concept developing in some hospitals, and he can be of assistance to physicians in pointing out dose inconsistencies or potential drug interactions. But, why does the pharmacist want to take on the dangers of being the defendant found by a jury to be liable because he seeks the role of a subrogate practitioner by way of a legislated act to give him substitution or drug interchange authority?⁴

Lower Costs for Patients?

Some would try to convince a legislature there is public policy justification. Those who seek broad substitution power granted by state lawmakers give two reasons. One is the pharmacist's freedom to substitute would result in lower cost to patients. And, second, there is the claim that all drugs of the same chemical name are identical. If this were true, and it is not, the circle is completed on the cost issue solely.

Prescription drugs account for only about eight cents of each health care dollar, but that should not be a reason not to search for practical ways to reduce drug costs in the total treatment expense, wherever that expense falls for payment.

Some cheaper long-established drugs may be purchased by a pharmacy usually from repackers or regionally limited distributors or manufacturers. Some well-known brand name drugs may sell at different prices at different pharmacies, however, it is not the intent of this commentary on substitution to get into the unresolved question of price-posting for consumer comparison.

Prescribers should make themselves aware of comparative prices and reliability of manufacturers

for any of the drugs they routinely use. Where cost is important to the patient, the selection of rational alternative therapy, the limitation of the number of prescriptions to those absolutely essential, and prescription in manufacturer's smallest packaged quantity (especially when the drug is already in a safety closure package) are some helpful suggestions and, in fact, such steps by the prescriber would be preferable to having a cost factor determination made by any third party.

There may be, therefore, reasonable solutions to the drug cost question. Generic prescribing or generic substitution is not one of them. Experience in some states and in Canada is reported to show the patient did not benefit from any expected savings. No consumer savings have resulted.

Recently, two surveys revealed the public believes physicians should have the final decision on what drug product is used to fill a prescription. In one poll, Wisconsin people were 75 percent in favor of allowing the physician to choose both the drug and the drug manufacturer. About two-thirds were opposed to substitution without the prescriber's consent.

In a national survey, the public reaction was remarkably similar and more than 70 percent said they did not want "similar drug products" substituted even if the product cost less than those prescribed by their physician. One conclusion from this current attitude survey is that patients are more quality conscious than price conscious when it comes to their personal medical care.

Equivalency of Drug Products

The backers of substitution legislation stress equivalency of drug products. Are not all products identical if they contain the same active medicinal ingredient? The answer is, surprising as it may be, no.

The Office of Technology Assessment (OTA) was requested to report on assurances of the equivalency of multisource prescription drug products.⁵ The study, headed by the dean of Yale University School of Medicine, was conducted because Congress was considering the proposal to reimburse under federal programs only for the lowest priced generally available drugs deemed to be chemically equivalent under present standards. However, under present standards as applied and enforced by the Food and Drug Administration, there is no certainty that pharmaceutical products containing the same active ingredients can be depended upon to produce the same therapeutic effects.

In 1974, the OTA panel reported: "Current standards and regulatory practices do not insure bioequivalency for drug products . . ." Obviously, this report to the Congress indicates the real problem is the assumption chemically "identical"

drugs are the same. They are not. The report cautioned that undetected cases of inequivalency are likely.

Several examples of inequivalency have been published. "Variations in bioavailability of drug products have been recognized as responsible for a few therapeutic failures. It is probable that other therapeutic failures (or toxicity) of a similar origin have escaped recognition."5 The OTA panel observed that for drugs with a relatively narrow margin of safety which are generally administered in doses that produce plasma levels not much higher than the minimum level required for efficacy, "therapeutic inequivalence, must certainly occur whenever there are substantial differences in bioavailability." Even within any group of drugs for which minor variations could be of little or no therapeutic consequence, the panel concluded "there is room for considerable improvement of standards for control of manufacturing processes and the testing of products."

FDA Control of Generic Equivalents

The OTA recommendations were aimed at giving the FDA better standards for manufacturing practices and surveillance. And, on this point, the widely known research and quality control oriented manufacturers favor federal legislation to actually identify on the label the manufacturer of a finished dosage form if that manufacturer is different from the person assuming responsibility for the product distribution. As of March, 1975, the FDA has not published regulations responsive to the OTA recommendations. The OTA chairman in testimony before a U.S. Senate committee in March, 1975, suggested "tightening" of U.S.P. (N.F.) standards but obviously there is much work to be done to revise the U.S.P. before there is a reliable list of "interchangeable products."

The need to test generic or chemical equivalents for pharmacologic and bioavailability equivalence, as recognized by the OTA, means the FDA budget must be increased if that federal agency is to fulfill its mandate to give the public safe and effective pharmaceuticals. The FDA inspects and tests but are the inspections and testing adequate to protect public health? There have been other solutions discussed. They tend to be duplicative, subject to variability of purpose and application, and above all, impose reverse economics on the reduced cost objective.

In Canada, when generic replacement was debated many years ago, the then apparent inability of federal surveillance and testing to ensure "equivalence" produced the proposal that the testing responsibility should be provincial. Likewise, in this country some states have considered entering into the complex field of drug testing to arrive at a listing of "equivalent" products. One state re-

cently turned to its state university school of pharmacy for an estimate for laboratory testing for bioavailability equivalence of drug products. The cost was placed at almost \$300,000 for the first year and about \$170,000 for each following year plus other expenses. A state-by-state approach to the preparation of an acceptable list of specified products of specified manufacturers which could be used interchangeably with continuing testing would have negative economic impact upon already strained budgets.

The Physician Must Decide

The present situation is that drug equivalency cannot be assumed.

Since this is the situation and until FDA regulations can be more effectively implemented, is it not better to place the patient's well-being in the hands of the prescriber so that he alone makes the ultimate therapeutic choice decision?

It is the physician who knows the patient and has the skill and knowledge to make his informed selection of what drug—what specific drug by name and known manufacturer—is indicated for the patient. This does not preclude the prescriber from writing by generic name instead of brand name nor does it preclude his assent when contacted by the pharmacist to specify another drug. It remains within the control of the prescriber to give or withhold his approval of what shall be dispensed. His selection of the generic product should be based, however, on the same informed choice so he is confident the drug is pharmacologically identical to an alternative choice.

The National Research Council's Drug Research Board (DRB) in January, 1975, took a position supporting substitution in the absence of any data indicating the substituted drug is not equivalent. The position is based on two premises: The pharmacist has "greater knowledge of drug products than other health professionals, including knowledge of both quality and costs" and "the physician must have the ultimate responsibility and authority in drug product selection, since he has the fullest knowledge of the patient's needs and responses with the attendant obligation to be held accountable for his selection of particular drug products." The italics have been added to suggest incompatible differences between the role assigned the pharmacist and physician by the DRB. Without debating the question of where the "greater knowledge of drug products" rests, the emphasis is more properly directed again to where does the duty to the patient lie for treatment and where will the jury place the fault if there is harm alleged from the drug administered.

Several states have "legalized" substitution by permitting the physician to delegate to the pharmacist the right to make the choice of substitution for the written order or reserve explicitly to himself the instruction not to substitute. If the prescriber delegates the important decision of which drug the patient will receive, he has made the pharmacist his agent and he is responsible for the substitution even when the physician has no knowledge of what drug was substituted. There could be fact situations where the pharmacist or those who select drugs to be listed in a formulary could be found legally liable for harm resulting from a substitution without input decision by the prescriber.

Legal Complications Are Unclear

The DRB position does not make the potential legal complications any clearer and attorneys may find interesting the placement of "accountability": "For the physician, he must be prepared to defend his decision to restrict the dispensed drug product to the specific brand named in his prescription, should he choose to require such a restriction. For the pharmacist, he must be prepared to defend his substitution of a cheaper drug product than a brand named in the prescription, should substitution be permitted by the physician."

In summary, a prescription substitution by the pharmacist, without or with express or implied assent of the prescriber, effectively voids the prescriber's first choice of drug for each individual patient. The physician places himself in a position of having to know that the substituted drug dispensed is bioequivalent. Even if a state law were to permit the substitution with a physician's assent, there is no current federal standard or regulatory program to ensure each and every product labeled as "identical" is truly equivalent.

A further difficulty comes in the assignment of legal liability. In tort law the longstanding rule is the defendant at fault is determined by his act or omission of an act arising from a duty owed to another person is the proximate cause of injury. Simply put, this means a drug improperly prescribed usually places the liability burden upon the pharmacist; a drug improperly manufactured puts the liability upon the producer.

The manufacturing source of the substituted product may be hard to trace and prove. The suing party will claim the prescription, as written, speaks for itself. Authorized substitution presents a potential legal problem for the physician and pharmacist if the drug substituted (X1 for X) was not as labeled X1 on the dispensed container and the substituted drug written on the original prescription order.

The patient based his or her informed consent on X. The patient expected X to cure or alleviate the illness. The public does not expect to be misinformed by pharmacist or physician—X

means X. This attitude is more threatening today in light of the trend in some courts to impose a greater duty upon the physician to disclose all material risks upon which the patient makes an informed decision. How can the physician explain a risk for a product selected by a pharmacist who controls what drug is finally dispensed?

Heed the words of a lawyer⁶ who wrote: "Let us, as lawyers, acknowledge we have no license to practice medicine. Yet, we license a lay jury to practice the art every time a complication occurs for which the patient claims he was not advised!"

Who has a license to practice medicine? This question is not asked to be argumentative nor to diminish the present professional role of the pharmacist. It is necessary, absent positive economic benefit, to point out that substitution legislation enacted by a few states could present entirely new professional liability problems for the pharmacist and/or the prescribing practitioner. Better to avoid substitution by statute rather than put the liability questions to a court test.

Footnotes

 Canterbury v. Spence and Washington Hospital Center, 464 F.2d 772 (D.C. Cir. 1972). Canterbury is a seminal decision and controversial to the extent a seminal decision and controversial to the extent the state courts are beginning to follow the decision which greatly increases the malpractice liability exposure of the physician. "... the test for deter-mining whether a particular peril must be divulged is its materiality to the patient's decision; all risks potentially affecting the decision must be un-masked. And to safeguard the patient's interest in achieving his own determination of treatment the achieving his own determination of treatment, the law must itself set the standard for adequate disclosure" is the guts of Canterbury.

The courts generally recognize exceptions to the informed consent doctrine where consent is not feasible e.g. emergency treatment, or the risk disclosure would be detrimental to the patient's best interests in the professional judgment of the treating physician. These exceptions apply to investigational new drugs also when research is conducted by qualified clinical investigators. 21 CFR 312.

by qualified clinical investigators. 21 CFR 312.

2. ". . . every human being of adult years and sound mind has a right to determine what shall be done to his own body." Schloendorf v. Society of New York Hospital, 211 N.Y. 125, 105 N.E. 92 (1914).

3. Private Practice 3:39, (June) 1971.

4. In Ohio, a "prescription" is defined by statute to mean "an order for drugs or combinations or mixtures" by a "practitioner." The "practitioner" is clearly identified by Ohio lawmakers as a physician or surgeon, a dentist, or a veterinarian who is or surgeon, a dentist, or a veterinarian who is "authorized by law to write prescriptions for drugs or dangerous drugs." See Ohio RC §§4715, 4729, 4731, 4741. In about 150 pages of Ohio statutes dealing exclusively with occupations and professions the local statutes and professions. sions, the legislature properly has not recognized any other member of a profession can superimpose

any other member of a profession can superimpose a judgmental decision, even with best intention, upon the prescription order of legally designated practitioners.

Furthermore, federal law (21 U.S.C. 353) explicitly limits prescription authority to a licensed practitioner, and an "act of dispensing a drug contrary to the provisions . . . shall be deemed to be an act which results in the drug being misbranded . . ."

5. Drug Bioequivalence, A Report of the Office of Technology Assessment, Drug Bioequivalence Study Panel, U.S. Government Printing Office, 1974.

6. Markham, B. B., The Doctrine of Informed Consent —Fact or Fiction?, 10 Forum 1073 (1975).

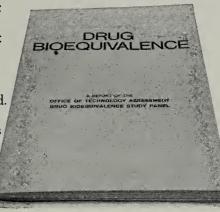
the weight of scientific opinion:

If the pharmacist substituted a chemically equivalent drug for the one you have specified for your patient—could you be certain of that product's safety and effectiveness simply because the chemical content was the same?

Definitely not, unless bioequivalence tests and other quality assurance checks had been conducted. The pharmaceutical industry and many scientists have maintained this position for years, but others have questioned it. Now the Office of Technology Assessment of the Congress of the United States has reported on the issue in its Drug Bioequivalence Study.*

Here are a few definitive statements in the O.T.A. report:

"... the problem of bioinequivalency in chemically equivalent products is a real one. Since the studies in which lack of bioequivalence was demonstrated involved marketed products that met current compendial standards, these documented instances constitute unequivocal evidence that neither the present standards for testing the finished product nor the specifications for materials, manufacturing process, and controls are adequate to ensure that ostensibly equivalent drug products are, in fact, equivalent in bioavailability.



"While these therapeutic failures resulting from problems of bioavailability were recognized and well documented, it is entirely possible that other therapeutic failures and/or instances of toxicity that had a similar basis have escaped attention."

The Pharmaceutical Manufacturers Association supports federal legislative amendments that would require manufacturers of duplicate prescription pharmaceutical products, subject to new drug procedures, to document:

(a) chemical equivalence; and

(b) biological equivalence, where bioavailability test methods have been validated as a reliable means of assuring clinical equivalence; or (c) where such validation is not possible, therapeutic equivalence.

In addition, the PMA supports federal legislation that would require certification of all manufacturers of prescription products before they could start in business, annual inspections and certification thereafter, and strict adherence to FDA regulations on good manufacturing practices.

The overall quality of the United States drug supply is excellent. But only a total quality assurance program, envisaged in these and other policy positions adopted by the PMA Board of Directors in 1974, can bring about acceptable levels of performance by all prescription drug manufacturers and thereby assure the integrity of your prescription...



Pharmaceutical Manufacturers Association 1155 Fifteenth Street, N.W. Washington, D.C. 20005

*Copies of the complete report on Drug Bioequivalence may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

protecting the integrity of your prescription

Physicians Play Vital Role In Drug Enforcement Conference

William H. Havener, M.D.*

Nine representatives of OSMA, Ohio's medical schools and the Ohio State Medical Board participated in a "Conference of Concerned Professionals" sponsored by the federal Drug Enforcement Administration (DEA) on March 5-6 in Columbus.

Also participating were Ohio representatives of dentistry, nursing, pharmacy, osteopathy and veterinary medicine.

Your representatives included Milton M. Parker, M.D., Columbus; John B. Chewning, M.D., Cincinnati; Henry G. Cramblett, M.D., Columbus; Leroy B. Goodson, M.D., Springfield; William H. Havener, M.D., Columbus; William Lee, Columbus; Arnold M. Leff, M.D., Cincinnati; David G. Logan, M.D., Cleveland and Anthony Ruppersberg, Jr., M.D., Columbus.

The Drug Enforcement Administration is the sole federal group responsible for dealing with drug abuse problems within the United States (it is also concerned with drug sources abroad as they might relate to the U.S.). The purpose of the conference was to further develop working relationships between DEA and health professional groups. Such conferences have previously been held in Pennsylvania, California, and Kentucky. The Ohio conference is the fourth such meeting in a series intended to include all states.

The DEA has recognized the existence of at least two entirely different aspects of drug abuse and enforcement. The illegal substances include heroin, LSD, and marijuana—drugs which have no recognized medical use. Other than through research, the health professions are not presently involved in this aspect of drug abuse. The second group of drugs includes those with accepted medical value, but which are subject to abuse for psychotropic purposes (for example, narcotics, barbiturates, amphetamines, etc.) Obviously, physi-

cians use these medications and have some control over public access to such drugs.

In most of the government-physician relationships we have encountered, the government stipulates what we shall do. Sometimes euphemisms such as "self-regulation" and "voluntary compliance" are used. Nevertheless, the clear implication is that a regulation has been issued and will be obeyed. However, an unexpected attitude appeared in this conference. The relationships envisioned by the DEA with medicine hopefully will not be new and more restrictive regulations. While older and wiser physicians may say, "Just wait and see what happens!", your representatives were convinced of the sincerity of the DEA staff.

The DEA objective appeared to be a sincere attempt to combat drug abuse through a cooperative and noncoercive common effort. You and I oppose drug abuse. So does the DEA. They are our official representatives, entrusted with the task of protecting us against the recognized consequences of drug abuse. The plain fact is that they cannot totally protect us. We must help ourselves.

Hence, the objective of the Conference approach is to establish a candid relationship between DEA and health professionals, with the aim of establishing a framework for effective combatting of drug abuse among professionals. This framework is to be established under local medical control. The role of the DEA is to be a resource available for use as requested. Apparently the law is also written in this fashion, inasmuch as federal "teeth" are directed towards control of manufacturing and wholesale aspects of drug distribution; whereas retail outlets (pharmacies, dispensing by physicians) are subject to state regulation via the professional Board mechanisms.

The representatives of the Ohio State Medical Board confirmed they had received excellent cooperation from local DEA agents during the past year. Apparently our Board has very limited financial resources and is inundated by licensing problems, ethical complaints, and routine business. Not only is the added investigative manpower from the DEA welcome when drug misuse problems are suspected, but also, these agents are particularly

^{*}Dr. Havener, a Columbus ophthalmologist, is chairman of the OSMA Committee on Pharmacy, chairman of the American Association of Ophthalmology's Drug Committee; author of Ocular Pharmacology, 3rd edition; delegate to the U.S.P. Convention on behalf of both OSMA and the Ohio State University College of Medicine; and chairman of the Department of Ophthalmology, The Ohio State University College of Medicine.

knowledgeable in this complex field.

The conference participants were initially unaware of the DEA's attitude toward the health care professional. The DEA staff emphasized that they view most professionals (physicians, dentists, pharmacists, nurses, veterinarians) as relatively unlikely to be involved in drug abuse problems. In Ohio, for instance, with about 13,000 physicians involved in patient care, only five physicians surrendered their right to prescribe scheduled drugs last year. How many offenders remain undetected is, of course, unknown. Actually, I can think of several physician acquaintances who became dependent on drugs. Can you think of some of your acquaintances who have encountered such problems?

The drug-abusing professional is not only ill himself, but represents a potentially dangerous leak in the distribution of controlled substances. The Conference participants and DEA representatives were in complete agreement that an important common goal is to manage in the most constructive way possible the sick professional. The tools to be used, in ascending order depending upon the severity of the problem, include:

1. Unofficial discussions of problems with the affected physician.

- 2. Use of special committees of county medical societies or OSMA (newly-developed Subcommittee on Physician Effectiveness soon to be operational) for confidential counseling and possible referrals for treatment and rehabilitation.
- 3. Disciplinary hearings.
- Suspension of narcotic license(medical practice permitted except for use of controlled substances.
- 5. Revocation of license to practice medicine. Steps 3, 4 and 5 are taken by the Ohio State Medical Board, and are not initiated by the DEA. Actually, no one wants to lose the health care resource of a practicing physician if his effectiveness can be retained or if he can be rehabilitated.

A second common goal is to decrease the availability of drugs subject to abuse. Unfortunately this seems easier to discuss than to accomplish. The professional present seemed in unanimous agreement that an increasing complexity of regulations would not help very much and might even be counter-productive. For example, the regulation that a pharmacy should keep all its controlled drugs in a locked area has resulted in increased convenience for the criminal, who now finds all the good drugs in one spot. Also, as more and more drugs are controlled, a substantial cost is incurred and must be passed on to the consumer.

The amount of regulation necessary to provide the teeth needed by the Medical Board is probably best determined by the practical experience of the Board and of the DEA, but should be minimized. Most of the participants believed that the distinction between over-the-counter drugs and prescription-only drugs constituted fairly adequate control except for the hard narcotics.

The behavior of the narcotic criminal was a recurring subject of discussion. Night burglaries and armed robberies of pharmacies are ever increasing and frighten the pharmacist even more than malpractice problems distress the physician. Worse, the criminal is usually a repeater, released by the courts. Therefore, a third common goal is to improve enforcement of existing criminal laws. But how may this be accomplished?

Apparently, the DEA hopes it can mobilize professional and public opinion by means of these conferences in order to overcome the ancient adage, "The triumph of evil requires only that good men do nothing."

At a minimum, and for practical purposes, we ask you to please do the following:

- 1. Keep your prescription blanks in a safe place.
- 2. Keep your drug supplies small in amount and secure against easy pilferage.
- 3. Be alert to the patient seeking drugs too obviously for a fabricated complaint.
- 4. Avoid polypharmacy.

If you are aware of a problem with a sick physician, contact your county medical society special committee or the OSMA Subcommittee on Physician Effectiveness. For prompt help in the evaluation of a "street drug problem," contact your local police department or the Detroit Regional Office of DEA (313) 226-7290.



AMA Activities

Who Has The Last Word On Judicial Matters?

Two OSMA members, P. John Robechek, M.D. and Richard L. Meiling, M.D., recently met with the AMA Council on Constitution and Bylaws to present Ohio's position on a constitutional question.

The question concerns which body has the final authority in judicial decisions—the AMA House of Delegates or the Judicial Council? During the AMA Clinical Convention held in Portland last December, the OSMA delegation introduced Resolution 22 (C74) in order to clarify this constitutional question.

Resolution 22 (C74) is titled "Definition of the Authority of the House of Delegates over the Judicial Council." It pertains to the authority vested in the House of Delegates by Article VI of the AMA Constitution, which states "The legisla-

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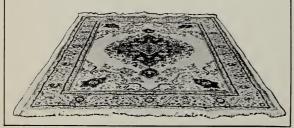
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tive and policy-making body of the Association is the House of Delegates. . ." The article appears to vest all authority in the House of Delegates. However, the Bylaws (Chapter XI, Section 11, Page (D)(1)) state "The Judicial power of the Association shall be vested in the Judicial Council, whose decision shall be final."

As background information, remember that Chapter XI, Section 1 of the Bylaws establishes five standing committees (Councils) of the House of Delegates including the Judicial Council. Members of the Judicial Council are nominated by the President and elected by the House without the privilege of acting on any candidate not nominated by the President.

OSMA introduced Resolution 22 (C74) hoping to correct the dichotomy of statements through a parliamentary review of the conflicting words and an amendment to the Bylaws. It may be necessary to amend the Constitution as well, but at this time no proposal has been submitted.

Annual Meeting June 14-19

During the AMA Annual Meeting in Atlantic City, the Ohio Delegation will be headquartered in Hotel Chalfonte-Haddon Hall. The delegation's Hospitality Room is open to all OSMA members and families. Comments and suggestions are welcome concerning the numerous reports of the AMA Board of Trustees, Committees, Councils, and the resolutions submitted by state and territorial societies, specialty groups, interns, residents and medical students.

On Saturday afternoon, June 14, open hearings are planned by the "Special Committee of the House" (Painter Committee). All AMA members are welcome to participate in the discussions before this committee. AMA members are also invited before all Reference Committees of the House, which will conduct hearings beginning Monday, June 16.

AMPAC Candidates Win

Of the 248 candidates AMPAC supported for the House of Representatives in the 1974 election, 183 were successful, for a winning percentage of 73.8. AMPAC supported 22 Senatorial candidates and 14 (63.6 percent) won election. During the two-year campaign — 1973 and 1974 — AMPAC contributed \$1,104,305.19 to candidates. In 1974, AMPAC filed contribution reports with the federal government 198 times.

Apply Now For OSMA's 1975 Family Practice Scholarships

Applications are now being accepted for the Thomas E. Rardin Family Practice Scholarships, sponsored by the Ohio State Medical Association. The two scholarships of \$2,000 are awarded annually to interest medical students in practicing family medicine in Ohio.

The scholarships are named in honor of the late Thomas E. Rardin, Sr., M.D. of Columbus, a leader in the family practice field who helped establish the Ohio Academy of Family Physicians. Dr. Rardin died in March, 1972 after 40 years of practice.

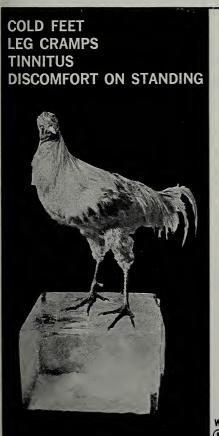
Candidates are required to be Ohio residents, to have completed their pre-medical education, and to have been accepted by a medical school. Application must be made in the year of entering medical school, but prior to beginning medical studies. Candidates are judged on the basis of interest in family practice, leadership, interest in community activities and organizations, intelligence, maturity, scholastic ability, and need.

Administered by the OSMA Family Practice Scholarship Subcommittee, the program pays each recipient from a four-year medical school \$500 annually. Payment dates are arranged with students enrolled in three-year medical schools. The award is paid directly to the winners. This marks the 27th year for the OSMA-sponsored scholarships.

Application forms may be obtained from the Family Practice Scholarship Subcommittee, Ohio State Medical Association, 600 South High Street, Columbus 43215. Completed applications must be in the OSMA office no later than June 1, 1975. Also, all candidates will be required to attend a special luncheon sponsored by the Family Practice Scholarship Subcommittee on Wednesday, June 18, 1975 at the OSMA office in Columbus.

Recipients of the 1974 scholarships were Ms. Gayle Anne Galan of Cleveland, now attending Case Western Reserve School of Medicine, and Michael Gaudiose of Youngstown, now attending The Ohio State University College of Medicine.

Other medical students currently on the Thomas E. Rardin Family Practice Scholarships include Donald J. Kennedy of Cincinnati, University of Cincinnati College of Medicine; Mrs. Phyllis A. Hutson of Maple Heights, Case Western Reserve School of Medicine; Carl S. Wehri, Cloverdale, The Ohio State University College of Medicine, and Albert J. Weisbrot, Cincinnati, University of Cincinnati College of Medicine.



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OSU Receives \$10,000 To Pinpoint Balance Disorders

Researchers at Ohio State University are developing a process that will help doctors pinpoint the cause of specific forms of balance disorders.

The Ohio State University College of Medicine recently received a \$10,000 grant to pursue a study of balance disorders. The grant is one of 28 awards totaling \$260,000, made by the Deafness Research Foundation for medical research across the country.

Dr. Charles W. Stockwell, assistant professor in the department of otolaryngology, is directing

the project.

The investigation involves the development posturography, a technique used to measure equilibrium. The clinical test aids in the diagnosis of dizziness, vertigo and other balance problems, according to the director. The process utilizes a device which indicates a patient's ability to maintain balance under special conditions.

The machine will be built on campus at an estimated cost of \$4,000. Completion of the device, consisting of a two-foot-square platform mounted on a hydraulic system, is planned for late spring. Actual testing is expected to begin in June.

Under the new testing procedure, the patient will stand on the platform and try to maintain his balance. The hydraulic system enables the machine to produce a swaying motion which makes balancing more difficult.

Current testing is extremely time consuming and doesn't necessarily provide all the information needed for an accurate evaluation, said Dr. Stockwell.

"The new test might eventually be used for screening to see if further testing needs to be done," he said. "Patients will participate in the research project strictly on referral by their physicians."

The Ohio State University Hospital Clinic tests approximately 600 patients for balance dis-

orders each year.

Four Named To Wright State's School of Medicine Faculty

Four new appointments to the staff of Wright State University's School of Medicine have been announced by Dean John R. Beljan, M.D.

• James W. Funkhouser, M.D., Kettering, Ohio, has been named clinical professor and chairman of the Pathology Department. His primary objective is to establish pathology in the medical curriculum and recruit physicians. Over the next few years, he plans to expand the department's

staff to five full-time professors. Dr. Funkhouser is a cum laude graduate of The Ohio State University College of Medicine. He has directed the diagnostic laboratories at Miami Valley Hospital and currently is president of the board of trustees of the Bureau of Medical Economics of the Montgomery County Medical Society.

- Samuel N. Kolmen, Ph.D. has been appointed jointly by the School of Medicine and the College of Science and Engineering as professor and chairman of physiology programs. A native of Brownsville, Texas, Dr. Kolmen's responsibilities include integrating the physiology curriculum into the overall course work. He was a research coordinator at Shriners Burns Institute in Galveston, Texas and a professor of physiology at the Galveston medical branch of the University of Texas.
- David P. Nicholson, M.D. has been appointed a professor of medicine to work with Dayton area hospitals in supporting community education programs about lung disease. Previously an Associate Professor of medicine at the University of Kentucky Medical School, Dr. Nicholson is a graduate of the University of London, Guy's Hospital Medical School in England.
- Nicholas J. Thompson, M.D. has been named clinical professor and chairman of the Wright State University School of Medicine's OB-GYN Department. Dr. Thompson will establish the department's curriculum and recruit physicians for its faculty. He will also coordinate the OB-GYN residency programs at area hospitals. For the past ten years, Dr. Thompson was in charge of Miami Valley Hospital's OB-GYN education department. A native of Norwalk, Ohio, he is a graduate of the University of Cincinnati College of Medicine.

To Establish Medical Dietetics Residency

Ohio State University's medical dietetics division of the School of Allied Medical Professions has received a \$267,000 grant from the W. K. Kellogg Foundation of Battle Creek, Mich.

The four-year grant will be used to establish and maintain a medical dietetics residency program at Ohio State's allied health complex.

"The residency will offer post-master and postdoctoral candidates the experience needed to teach in coordinated undergraduate programs," Dr. Maxine Hart, director of the division, said.

According to Dr. Hart, there is a critical shortage of instructors for the 45 approved coordinated undergraduate programs in the United States. Residencies will vary from three months to a year in duration, depending on the needs of the candidate.

Television To Help Doctor Care For Patients

Modern communications capabilities are being put to work by the University of Cincinnati Medical Center to help physicians improve patient care.

A model system using telephone and television to carry medical information directly to physicians in patient care areas is being developed at the Medical Center Libraries. Supporting work on the model is a grant from the National Library of Medicine. This is believed to be the first time in the nation that TV is being taken into patient care areas for information dissemination to physicians.

Telephone and TV lines will link the model system's resource room (in the Health Sciences Library in the new Medical Sciences Building) to two outlets: To patient areas at Cincinnati General Hospital and to the Emergency Room at Children's Hospital Medical Center.

When physicians in the hospital call with specific patient problems, experienced personnel will make use of centralized special resources to generate the information. That material will then be sent via television back to the physicians.

At present the model is concentrating on drug information because there is a finite body of information in that field. After evaluation the model's impact on service to patients and education of medical personnel, a study will be made to determine benefits of expanding the program to a larger user group with larger base of medical information.

Case Western Reserve Receives Pharmacology Award

W. Leigh Thompson, M.D. is the recipient of the Burroughs Wellcome Clinical Pharmacology Award on behalf of Case Western Reserve School of Medicine. Dr. Thompson, Associate Professor of Medicine and Pharmacology, was recently chosen after a nationwide search to head the new CWRU Division of Clinical Pharmacology.

The 24th annual Burroughs Wellcome Award of \$150,000 will support Dr. Thompson's work and facilitate development of CWRU's Division of Clinical Pharmacology for the next five years. Aimed at stimulating excellence in teaching, training and research in Cinical Pharmacology, the award is given to an individual who has made the study of drugs in man his major career objective.

The Burroughs Wellcome Fund is a nonprofit agency established in 1955 by Burroughs Wellcome Company, a leading pharmaceutical company.

With an M.S. and Ph.D. in Pharmacology from the Medical University of South Carolina and the M.D. from Johns Hopkins, Dr. Thompson took his clinical training on the Osler Medical Service at Hopkins and joined the faculty in 1970.

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Following are names of new members of the Ohio State Medical Association certified to the headquarters office during March. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

Ashtabula (Ashtabula) C. K. Ramachandran

Manolo P. Mapa

Belmont (Bellaire)

Butler

Cesario E. Bondoc Hamilton William W. Creech Hamilton Peter J. Enyeart Middletown Mark D. Imwalle Fairfield Armando C. Llenado Fairfield Robert A. Love, III Hamilton Richard F. Martin Hamilton

Clark (Springfield) James N. Broock

Columbiana (Salem) Helouise Mapa-Culanculan Wilmer G. Heceta-Gao-ayCuyahoga (Cleveland)
Arvind M. Talati Mariella Boller
James F. Carney
Monroe Cole

Sebastian Cook Hugh M. Eisen Martin A. Gordon Gwynn L. Jelden Lawrence R. Jones Parvez B. Khambatta Kwon Soo Kim Roger H. S. Langston Chiu Ho Lee Jae Kyu Lee Yee Juan So Lim Philomena I. Luczek M. P. Patel Augusto D. Pichard Jose M. Rivera-Velez Robert J. Sating Ilze K. Schwartz

Cuyahoga / continued Mostafa A. Selim Riaz A. Tarar Paul C. Taylor Muhammad B. Ulvi Meredith A. Weinstein Phillip H. Weiss F. K. Zajicek

Franklin (Columbus except where noted) Richard H. Clary John A. Burkhart Antoinette J. P. Eaton Sami B. Girgis Samuel J. Kiehl, III Viera J. Kirilcuk Thomas F. Kravec Robert E. Lembach Ernest L. Mazzaferri Glenn L. Mohler Lowell R. Quenemoen Jeffrey L. Rizor Fred W. Worley Reynoldsburg Robert E. Zipf, Jr.

Hancock (Findlay) William H. Alcott William H. Kose

Jefferson

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OSMA Starts Campaign To Show Medicine Is Doing A Good Job

The issues of medicine and health rank No. 1 in the interests of today's public, according to surveys of newspaper and radio-TV audiences. OSMA has decided to respond to this deep interest by embarking on an intensive public information campaign. Not only will the campaign show Ohio citizens that the medical profession is doing a commendable job, it will also alert them to hazards and advantages of present and proposed legislative programs.

To implement and develop the campaign, the OSMA Council created a full-time Department of Public Relations. Charles W. Edgar, Director of Public Relations, has been relieved of all nonrelated staff assignments in order to devote his full time to internal and external public relations. Also, Rebecca J. Doll has joined the headquarter's staff in the new position of Manager of Media Relations.



Rebecca J. Doll

Ms. Doll will handle the preparation and publication of materials developed for the public information campaign, including:

 A monthly tabloid newspaper, titled Your Doctor Reports, to be sent to all OSMA members for patients to pick up in the waiting room.

· A health column for Ohio's weekly newspapers, and a feature article for the Sunday newspaper editions.

• A weekly health news script for Ohio's radio stations.

Ms. Doll was director of public information for the Ohio Department of Health for nearly two years before accepting her present position. She is a 1973 graduate of The Ohio State University's School of Journalism and is currently a candidate for a Master of Arts degree. A native of Troy, Ohio, she is married to James A. Hammerschmidt, a Columbus attorney.

Ohio Scientists Report On Eye Research Projects

The Ohio Lions Eye Research Foundation sponsored a presentation of eye research projects on April 6 at the Fawcett Center for Continuing Education in Columbus. The many scientists whose research is funded by the Ohio Lions reported on their ongoing research as well as future proposals.

Participating in the all-day convocation were the Departments of Ophthalmology of Ohio State University; University of Cincinnati; Case Western Reserve; Medical College of Ohio at Toledo; The Cleveland Clinic Foundation; and OSU College of Optometry and Institute for Research in Vision.

The 20,000 members of 625 Lions Clubs in 10 Ohio Districts raise over \$100,000 each year. Since 1952, they have contributed \$1,200,000 to Ohio institutions for support or seeding of research into blinding eye disease, diagnosis, biophysics and eye physiology.

Interested eye physicians and optometrists are urged to join their local Lions Clubs to aid in this valuable support of the eye research being carried

out in Ohio Institutions.

Northern Ohio To Receive Physician Assistant Program

Cleveland Clinic Foundation and Lake Erie College will initiate a Primary Physician's Assistant baccalaureate program as a cooperative venture this fall. This is Northern Ohio's first baccalaureate Physician's Assistant program, and the first in the nation for a women's college. Although there are approximately 20 similar programs in the United States, this is one of the few offered to applicants who have no previous health care experience.

Graduates of the four-year course will be awarded Bachelor of Arts degrees from Lake Erie College and appropriate certification from Cleveland Clinic. The academic program at the College will provide the first three years of the student's education. This will include a background in the life sciences, including training in psychology, sociology and social service. In addition to classroom work, students will serve in three field assignments in health-related social service agencies and in a private physician's office. Part of the program includes an Academic Term Abroad in the Junior year, part of Lake Erie's normal curriculum. The fourth year will be spent at the Cleveland Clinic and other medical institutions where students will gain the technical training necessary for certification as a Physician's Assistant.

Ohio MD's Named Fellows Of Amer. College Of Radiology

Four Ohio physicians were cited for distinguished achievements by being named a Fellow of the American College of Radiology. The physicians are:

Antonio R. Antunez, M.D. of Gates Mills. A 1951 graduate of the University of Granada Medical School, Dr. Antunez is affiliated with the Cleveland Clinic.

John D. Dunbar, M.D. of Columbus. Dr. Dunbar, who graduated from Ohio State Unisity's College of Medicine in 1955, is affiliated with Children's Hospital in Columbus.

Tearle L. Meyer, M.D. of Columbus. A 1960 graduate of Ohio State University's College of Medicine, Dr. Meyer is affiliated with Grant Hospital in Columbus.

Ollie E. Southard, M.D. of Columbus. Graduated from the University of Pittsburgh in 1949, Dr. Southard is affiliated with Grant Hospital in Columbus.

Doug Freeman Joins OSMA's Field Service Department

OSMA's Field Service Department has been expanded to include an Associate Director, Douglas J. Freeman, who joined the Headquarter's staff in March.

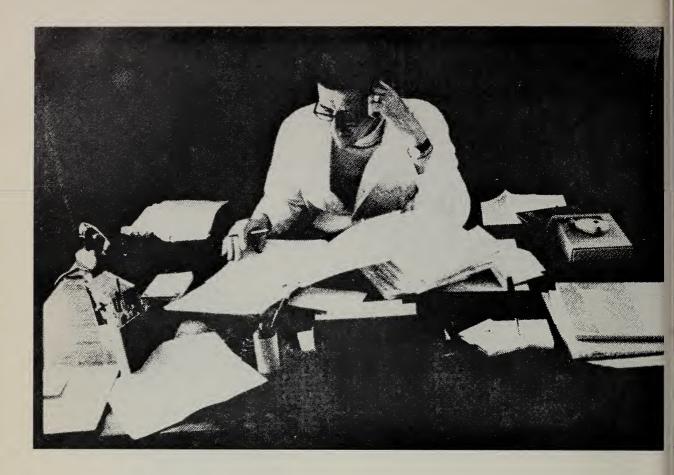


Douglas J. Freeman

The Field Service Department was created in response to a mandate by the 1974 House of Delegates. The department's purpose is to strengthen the autonomy of the county societies while helping them develop a closer relationship with OSMA through direct communications and administrative assistance. Robert Holcomb, Field Service Director, and Mr. Freeman spend much of their time travelling throughout Ohio, visiting the county societies.

A native of Dayton, Mr. Freeman graduated in June, 1974 from the College of Wooster in Wooster, Ohio. He was enrolled in pre-medical studies and majored in chemistry. His father was the late Robert F. Freeman, Executive Director of Montgomery County Medical Society for 22 years. Mr. Freeman has two brothers who are physicians, Richard J. Freeman, an ophthalmologist practicing in Auburn, N.Y. and John R. Freeman, an orthopedic surgeon presently serving in the U.S. Navy.

Mr. Freeman plans to be married in June to Susan J. Vastyan, who is currently a student at the College of Wooster.



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OSU Oncology Unit Developed

The Ohio State University Cancer Research Center has been funded by the National Cancer Institute to develop a new interdisciplinary oncology (cancer) unit at University Hospitals. The 15-bed unit will be dedicated to cancer research, care and therapy with the Departments of Surgery, Radiotherapy and Medical Oncology combining efforts in cooperative approaches to cancer treatment. This interdisciplinary oncology unit will be located in the 5 east wing of Means Hall and is presently undergoing renovation and refurbishing. The projected opening date for the unit is June 1975.

Cleveland Clinic Surgeon Elected To Surgery Board

Dr. Robert E. Hermann, Head of the Department of General Surgery of The Cleveland Clinic Foundation, has been elected a Director of the American Board of Surgery. His term will be from 1975 through 1981. Dr. Hermann will serve as a Board representative from the AMA's Section on General Surgery. The American Board of Surgery.

gery is responsible for residency education programs in surgery and examines surgeons in this specialty for certification.

Joining the Cleveland Clinic staff in 1962, Dr. Hermann was named Head of the Department of General Surgery in 1969. He resides in Shaker Heights, Ohio. He received his undergraduate degree at Harvard University, his M.D. degree from Washington University, and took his surgical residency at University Hospitals in Cleveland, Ohio.

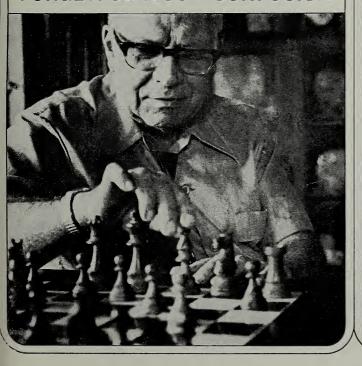
Alcohol And Mental Health

Alcohol related health problems for 26 percent of all admissions to State and county mental hospitals, according to the latest statistics published by the National Institute of Mental Health of HEW's Alcohol, Drug Abuse, and Mental Health Administration.

More than 40 percent of persons between the ages of 35 and 64 admitted to these institutions were diagnosed as having disorders related to alcohol abuse. For men in this age bracket, alcohol disorders were the predominant diagnoses, accounting for approximately 60 percent of the admissions.

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State Mental Institutions Desperately Need Physicians

Quantity and quality of the medical and psychiatric staffs in the State's mental hospitals, and institutions for the mentally retarded, has deteriorated dramatically since 1970, charged Timothy B. Moritz, M.D., Director of the Ohio Department of Mental Health and Mental Retardation. Testifying April 1 before the Education Subcommittee of the House Finance Committee, Dr. Moritz stated that present levels of medical manpower are grossly substandard, jeopardize the lives of institution residents, and seriously undermine the effectiveness of treatment and habilitation programs.

Dr. Moritz stated he has been shocked by the conditions which he inherited from the previous administration. The number of physicians (other than residents in training) and medical assistants in the State civil service in the Department's institutions has declined 37 percent since 1970. Only the use of expensive personal service contracts has prevented disastrous consequences. The diminution in medical manpower (not including residents in training) has been 20.9 percent since 1970 even with the assistance of contract employes. Overreliance on contract employes results in higher costs, poorer supervision, inefficiency, and loss of continuity of care. Many physicians hired on contract have refused to write medical orders or take responsibility for individual patient care in order to avoid court appearances, resulting in duplication and heavy loads for full-time civil service staff.

If recent trends continue over the next three months and the Department terminates the use of 41 medical assistants on July 1st in accordance with rulings of the Ohio Medical Board, the total loss of medical manpower in the State civil service will have been 40.7 percent since 1970.

The principal indicator of quality in medicine and psychiatry is Board Certification by the appropriate speciality board, Dr. Moritz said. The Department has only nine full-time and four parttime Board Certified psychiatrists in its 28 institutions. Eight of the thirteen Board Certified psychiatrists are at Cleveland Psychiatric Institute and Fairhill Mental Health Center in Cleveland, two of the Department's smallest facilities. Sixteen mental hospitals and six institutes for the mentally retarded have no Board Certified psychiatrists on their staffs. Thus, the absurd situation exists in which 62 percent of the Board Certified psychiatrists are in institutions with less than two percent

of the residents for whom the Department is responsible.

Five of the six State institutions for the mentally retarded have no Board Certified pediatrician. The Department operates three children's psychiatric hospitals and has no Board Certified child psychiatrists. Twenty-five of 28 state institutions have no Board Certified specialists in internal medicine. There are no specialists in neurology or rehabilitation medicine on the Department's total staff when there are thousands of institution residents with neurological and physical disabilities.

The net result has been an accelerating deterioration of the treatment and habilitation capacity of State institutions since 1970, in spite of substantial budget increases and the highly publicized humanization program. Dr. Moritz stated that, in effect, the State added some frills to its human warehouses. He agreed there have been improvements in basic custodial care, but he stated that the seriously deteriorating level of professional treatment threatened the lives and welfare of residents and made a farce of the terms "hospital, mental health center, and institutes" applied to the State's institutions.

If immediate corrective action is not taken, Dr. Moritz predicted there would be even more frequent individual incidents linked to poor medical care in the future. The more subtle, but more profound effect is the failure of patients to improve, resulting in chronic disability, increasing institutional costs over the long run. Dr. Moritz emphasized that to him the most essential ingredient of humanization is effective treatment and habilitation. The production of chronic institutionalization when it is unnecessary is the most dehumanizing thing which we can do.

With the complete backing of Governor Rhodes and Budget Director Collier, Dr. Moritz requested emergency action by the State Legislature to implement the recommendations of the Ohio Civil Service Commission in regard to the pay scale for physicians.

Dr. Moritz stated that competitive salaries are essential in order for the State to recruit and retain qualified physicians. Ohio's salaries for physicians are grossly non-competitive. They are lower than neighboring states, the Federal government. community agencies, and universities.

Woman's Auxiliary Highlights

Mrs. S. L. Meltzer, Communications Chairman 2442 Dorman Drive, Portsmouth 45662

"By the sea, by the sea, by the beautiful sea"
... Where else but Atlantic City? What else but
the fifty-third annual convention of the Woman's
Auxiliary to the American Medical Association?
When else but those "rare days in June"—the 15th
through the 18th? An exciting agenda includes outstanding speakers, a joint educational program
with the AMA and fun-filled evenings on the town.

Auxiliary headquarters will be the Howard Johnson's Motor Lodge, just a few steps from Atlantic City's famous boardwalk. A reception honoring Mrs. Howard Liljestrand, national president, and Mrs. Erle E. Wilkinson, president-elect, will be held on Sunday evening, June 15. The opening session of convention Monday morning will feature Malcolm Todd, M.D., AMA president, as the keynote speaker and presentation of awards for outstanding contributions to AMA-ERF.

A joint educational program planned by the AMA scientific assembly and the woman's auxiliary will be held on Tuesday afternoon, June 17. A new venture, the first joint program was held at the 1974 AMA Clinical Convention in Portland, Oregon, when physicians and their wives were encouraged to attend a session on human sexuality. While doctors' wives have been welcome and have attended scientific functions for many years, the new program offers sessions specifically designed for them. A highlight will be the luncheon program that day-a panel discussion on the world food shortage. Speakers will be Rene Dubos, professor emeritus of the Rockefeller University in New York City and Mona Doyle, director of consumer affairs for Food Fair Stores, Inc. Other topics on the scientific program will include "Estate Planning for Physicians and Their Families" and "Human Sexuality." Participants will also be invited to the AMA Conference on the Mental Health Aspects of Sports, Exercise and Recreation.

The Children's "Special"

There will be three days of youth activities—the 16th, 17th and 18th. Monday offers an introductory tour of Atlantic City, then south to Cape May, the nation's oldest seaside resort including the restored Victorian Village, returning by way of the picturesque coastal highway. Lunch in Cape May

is included. Tuesday offers a full day in Philadelphia with stops at all the famous historical places. A visit to nearby Betsy Ross Home is also included. Next on the agenda is the largest of the United States mints, including a tour through the mint showing all stages in the making of U.S. coins. A visit to the Franklin Institute Museum will conclude the day. Again, lunch is included in the tour. Wednesday features a visit to Barnegat Lighthouse State Park and the Batsto Village, a restored community that once made iron and glass. The guided tour of the village will include a working gristmill and blacksmith shop and the mansion house. Yes, the "young 'uns" will have lunch provided that day too

Atlantic City is "unto itself." If you've been there before, you know how much you have to look forward to. If you haven't, make it a "must." You'll love it. Convention plans sound terrific, so do yourself a double favor!

Here and There

Woman in the News: Mrs. Paul Hahn, Tuscarawas county, was recently appointed to the Board of the New Philadelphia Department of Health. She is currently serving her second two-year term on the advisory board of the Home Health Agency of the Department of Health. In addition, she is in her second-year term as treasurer on the Board of Directors of Mobile Meals, and in her twelfth year on the Board of Directors of the Senior Citizens of Tuscarawas county which she helped to organize. Jo Hahn is a member of our state auxiliary's Central Office Committee and has served on the state board for a number of years.

A "Garden Party" in March? (Sounds like something out of Alice In Wonderland!) But that is just what the Hamilton county auxiliary "ordered" with its fashion-in-full-bloom program and it was the best Spring tonic possible Models wore a bright bouquet of fashions and footwear from the Shop for Pappagallo. A social hour and luncheon preceded the Garden Party—the proceeds from which went to the group's Philanthropic Fund.

(Continued on Next Page)

Woman's Auxiliary / continued

The Huron auxiliary was hostess to the 11th District meeting in April at the Sawmill Creek Resort Hotel. Each participating auxiliary in the eleventh district was asked to share one project or event that could serve as an "inspiration" to the others. This was followed by an open discussion. Following the twelve-thirty luncheon, Mrs. S. J. Glueck, state president, and Mrs. Robert Krone, state president-elect, spoke to the assembled auxilians in their inimitable enthusiastic styles. (These two state officers have a way of "capturing" their audience!)

Earlier this year the Lucas county group had what was described as the "Bus Trip of the Year." It had as its destination the Somerset Mall in Troy, Michigan and it was an all-day-fun-day. Included

were everything from luncheon at the French Cafe or Schrafft's Restaurant, to informal modelling by Saks, to browsing in Abercrombie and Fitch, Apagee III, Bally of Switzerland, F. A. O. Schwartz and many other outstanding shops.

Counties—Attention Please!

Copy in recent months for this column has had to be focused on a number of events and activities that have had to take precedence over county auxiliary activities. I shall try to make it up to you next month by dedicating the whole column to your activities and projects. All of you do such a tremendous job and I am deeply grateful for the material you send me. Please—keep on sending it!

Obituaries

Sidney Barnett Conger, M.D., Akron; Cornell University Medical College, 1918; age 81; died February 15; member of OSMA and AMA.

James Willard Coombs, M.D., Park Ridge, Illinois; University of Cincinnati College of Medicine, 1937; age 67; died March 8; former member of OSMA.

George Adalbert Csanad, M.D., Lakewood; University of Budapest, Hungary, 1939; age 60; died March 13; former member of OSMA and AMA.

Ralph James Frackelton, M.D., Lakewood; University of Michigan Medical School, 1918; age 82; died February 23; member of OSMA and AMA.

Harry Burman Frederick, M.D., Sandusky; Eclectic Medical College, 1910; age 94; died March 27; member of OSMA and AMA.

Waudell W. Hunter, Sr., M.D., Sandusky; Ohio State University College of Medicine, 1934; age 67; died March 28; member of OSMA and AMA.

A. Engle Lenhert, M.D., Cleveland; Hahnemann Medical College, 1941; age 64; died March 19; member of OSMA and AMA.

George Henry Mansfield, M.D., Florida; Western Reserve School of Medicine; 1943; age 62; died March 13; member of OSMA and AMA.

Floyd Schiefer Meck, M.D., Cleveland; Ohio State University College of Medicine, 1924; age 76; died March 19; former member of OSMA and AMA.

Joseph Schwartzberg, M.D., Cleveland; University of Michigan Medical School, 1923; age 74; died March 8; member of OSMA and AMA.

Herbert Elias Sloan, Sr., M.D., Clarksburg, W. Va.; Eclectic Medical College, 1898; age 99; died February 18.

Constantine Vishnevsky, M.D., Malvern; University of Kannas, Lithuania, 1933; age 66; died March 7; member of OSMA and AMA.

Theodore O. Walker, M.D., Cincinnati; Meharry Medical College School of Medicine, 1928; age 81; died March 19; former member of OSMA and AMA.

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As medical guide, family counselor, trusted friend—you, doctor, play a major role in the fight against cancer quackery.

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Our National Office maintains an up-to-date central clearing house for materials on unproven methods of cancer diagnosis and treatment. This is a unique operation and the principal source of such information in the

country. Its services are widely used. Hundreds of inquiries are received and answered from all segments of the community, from coast to coast.

To trigger grass-roots action, we have formulated a model State Cancer Remedy Act designed to control the promotion and sale of unproven methods of cancer management. This has already inspired nine states to legislate against cancer quackery—with active support from the medical community. Copies of the model act, as well as copies of the laws in effect, are available in our National and Division offices.

In these actions against cancer quackery, as in all our efforts against cancer, ours is a lifesaving partnership.

> American Cancer Society



CONTINUING EDUCATION OPPORTUNITIES

Ohio Colleges

Cleveland Clinic Educational Foundation For further information: 9500 Euclid Ave. Cleveland 44106

New Advances in Dermatology; May 15-16; \$80.

University of Cincinnati For further information: Office of CONMED 234 Goodman St. Cincinnati 45229

Advances in Internal Medicine; May 19-23; cosponsored by American College of Physicians; \$140 for ACP members, FACP and residents; \$200 for non-members; \$70 for ACP Assoc.
—Cincinnati

Mental Retardation; June 13; 9 a.m.; 36th Benjamin Knox Rachford Symposium; Research Auditorium of Children's Hospital Research Foundation.

Ohio State University
For further information:
Center for Cont. Medical Education
320 West Tenth Ave.
Columbus 43210

Electronystography Conference; May 21-22; \$100. Advances in Middle Ear Effusion; May 29-31.

In Ohio

Diagnostic Roentgenology; May 27-31; contact: Harold B. Spitz, M.D., Dept. of Radiology, Cincinnati General Hospital, Cincinnati.

Microneurosurgery Symposium; May 29-31; Cincinnati Convention Center; sponsored by Departments of Neurosurgery, The Christ and Good Samaritan Hospital; contact: S. Stuckey, 506 Oak St., Cincinnati 45219.

Fifth Annual Radiological Seminar; June 11; 8:30 a.m.-4:15 p.m.; Veterans Administration Center, Dayton; contact: Emil Gutman, M.D., Chief, Radiology Service, Veterans Administration Center, Dayton 45428.

Outside Ohio

Physics Review in Diagnostic Radiology, Nuclear Medicine and Radiation Biology—May 19-22; fee is \$200; designed principally for residents; contact: Krishnadas Banerjee, Ph.D., dept. of nuclear medicine and radiation oncology, St. Francis, General Hospital, Pittsburgh, Pa. 15201.

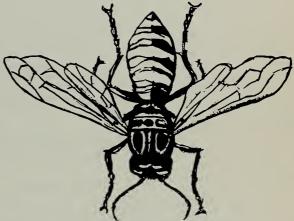
Physics of Radiology, Nuclear Medicine and Radiobiology—May 19-22; fee is \$50; designed principally for residents; contact: Jan U. Smulewicz, M.D., dept of radiology, Queens Hospital Center Affiliation, Long Island Jewish-Hillside Medical Center, 82-68 164th St., Jamaica, N.Y. 11432.

Twenty-Second Annual Meeting of the American College of Sports Medicine—Marriott Hotel, New Orleans, Louisiana; May 22-24; contact: Gary R. Jenks, Executive Secretary, American College of Sports Medicine, 1440 Monroe St., Madison, Wisconsin 53706.

Current Concepts in Radiation Therapy—Mayo Memorial Auditorium, Minneapolis; May 28-30; contact:

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Ms. Kathy Vegoe, program assistant, University of Minnesota, Continuing Medical Education, 1350 Mayo Memorial Bldg., Box 293, Minneapolis, Minn. 55455.

Surgery Review; June 1-5; University of Kentucky Medical Center, Lexington, Kty.; contact: Frank R. Lemon, M.D.; \$175.

Refresher Seminar in Pediatrics; June 2-6; contact: Continuing Medical Education, 2211 Main St., Buffalo, N.Y. 14214.

Emergency Medical Care — Medicolegal Implicacations; June 8-10; Statler Hilton Hotel, Washington D.C.; contact American Society of Law & Medicine, 454 Brookline Ave., Boston, Mass. 02215; \$150 for nonmembers; \$135 for members; \$20 for students.

27th Annual Meeting, Pennsylvania Allergy Association; June 13-15; Hotel Hershey, Hershey, Pa.

Hypertension 1975; June 26; University of Kentucky Medical Center, Lexington, Kty.; contact: Frank R. Lemon, M.D.; \$20.

Cardio-Pulmonary Emergencies; June 27-28; University of Kentucky Medical Center, Lexington, Kty.; contact: Frank R. Lemon, M.D.; \$75.

Histologic Diagnosis of Inflammatory Skin Diseases—Alumni Hall, NYU Medical Center, 550 First Ave., New York, N.Y.; June 26-28; fee is \$200; for residents \$100; contact: Office of the Associate Dean, New York University Post-Graduate Medical School, 550 First Avenue, New York, New York 10016.

Current Concepts in Radiology Including Diagnosis, Therapy and Nuclear Medicine—Atlantis Lodge, Atlantic Beach, North Carolina; July 21-26; fee is \$150; contact: Robert McLelland, M.D., Dept. of Radiology, Box 3808, Duke University Medical Center, Durham, North Carolina 27710.

Purdue Defibrillation Conference—Lafayette, Indiana; October 1-3; fee is \$95; contact: Division of Conferences and Continuation Services, Stewart Center, Purdue University, West Lafayette, Indiana 47907.



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In This Issue:

Air Force Opportunities348
Barry Laboratories
The Brown Pharmaceutical Co., Inc
Burroughs Wellcome Co366
Capital Financial Services317
The Christopher Inn333
Dorsey Laboratories, Div. of Sandoz-Wander, Inc
Flint Laboratories, Div. of Travenol Lab. Inc
International Travel Advisors, Inc322
Lilly, Eli and Company296
Maritz Travel Associates
McNeil Laboratories
Mead Johnson Laboratories293
The Medical Protective Company343
Menendian, K.A. Carpets334

Merck Sharp & Dohme, Div. of
Merck & Co., Inc
Ohio Medical Indemnity336
The Park Plaza Hotel315
Pharmaceutical Manufacturers Association
Robins, A.H. Company353, 354
Roche Laboratories, Div. of Hoffman- LaRoch, Inc Inside Front Cover, 291, 328, 329, 364, 365, Inside Back Cover, Back Cover
Roerig & Co., Div., Pfizer327
Searle Laboratories, Div. of G.D. Searle & Co
SK&F Co., Subsidiary of Smith, Kline & French Laboratories363
Turner & Shepard, Inc
University Center320
Wendt-Bristol Co
Windsor Hospital
Wolman Insurance Agency Inc345

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381

390

Original and Scientific Articles

REPLANTATION OF AMPUTATED EXTREMITIES. REPORT OF FIVE CASES. Stanley Jaffe, M.D.; A. Scott Earle, M.D.; Earl J. Fleegler, M.D.; and Elias A. Husni, M.D., Cleveland APPENDICITIS — STILL A POTENTIALLY LETHAL DISEASE. 387 John H. Hughes, M.D., and Roberta G. Kurtz, Phase III Medical Student, Toledo MATERNAL HEALTH IN OHIO:

Special Articles

396 CODING DISEASES & PROBLEMS

How and why you should be using Problem Oriented Medical Records Douglas P. Longenecker, M.D.

399 HOW A BILL BECOMES A LAW

A look at the legislative process in Ohio, especially timely for today's physicians.

AN INSIDE LOOK AT THE MEDICAL BOARD 407

OSMA interviews William J. Lee, Administrator of the Ohio State Medical Board.

MATERNAL MORTALITY REPORT FOR OHIO — 1972.

By the OSMA Committee on Maternal Health

Features

News	372	New Members	427
Comments	395	Woman's Auxiliary	428
Ohio Health News	413	Continuing Education	432
The State Scene	417	Obituaries	431
The Federal Scene	418	Journal Advertisers	433
Council Minutes	421	Classified Ads	435

ABOUT THE COVER: The House of Delegates installed OSMA's three leading officers during the 1975 Annual Meeting in Columbus, May 11-14. As Immediate Past President, James L. Henry, M.D. (left), addressed the House. Accepting the President's Medallion, Maurice F. Lieber, M.D. (upper right), became OSMA's new President. George N. Bates, M.D. (lower right) of Toledo was named President-Elect. Watch next month's Journal for a full account of the 1975 Annual Meeting.

OSMA To Conduct Another Membership Attitude Survey

OSMA's Council has accepted the Membership and Planning Committee's recommendation to followup the membership survey conducted in 1970 with a new survey. The survey's purpose is to give members an opportunity to be a closer part of the total OSMA team. Members' responses will function as input and direction to the officers and Council in their decision-making. Watch for the questionnaire which will be mailed with the OSMAgram.

The survey will cover many areas including continuing medical education, state and federal legislation, professional liability, peer review, etc. Data results will

be compiled by computer.

Questions contained in the 1970 survey have been used as a reference point in formulating this year's survey. Many questions will be similar to those of 1970 in order to determine the trend of membership attitude during the past five years.

The 1970 survey enjoyed excellent results with 5,400 of the 9,975 questionnaires returned by members

or a 55 percent response.

Osteopath School Bill Threat To Family Practice Programs

Family practice residency programs are the solution to Ohio's physician distribution problem, said OSMA's Council in its statement opposing H.B. 229. The bill, presently before a Senate committee, would appropriate \$670,000 to establish a college of osteopathic

medicine as part of Ohio University.

OSMA believes the first priority is to retain Ohio medical school graduates in the State of Ohio. Family practice departments within Ohio medical schools and family practice residency programs, especially in community hospitals with university affiliations, should be expanded. Such an expansion was called for by H.B. 474 which the Legislature passed last year.

If there are not enough adequately funded residency programs, the State of Ohio may be developing physicians who will migrate to other states for residency pro-

grams and stay there to practice.

The second priority in the area of expenditures for physician education, according to OSMA, is funding of the six existing medical schools so they can continue their operation.

"An osteopathic school of medicine should be of

last priority and in our opinion is contraindicated at this time," stated OSMA's Council.

H.B. 229, which passed in the House by a 90-4 vote, allows the appointment of an advisory board and administration for the osteopathic college. According to the bill, clinical instruction would be provided through the facilities of existing osteopathic hospitals. H.B. 229 also requires that at least 80 percent of students attending the new college be Ohio residents.

The Ohio Academy of Family Physicians has also taken a stand against creating a new college for the production of physicians. The Academy believes Ohio will be producing a sufficient number of new physicians by 1982. Furthermore, the Academy feels taxpayers' money would be more effective if used to retain new physicians in Ohio through expansion of residency training programs.

Also opposed to the osteopathic college are the Ohio Board of Regents and the Ohio Valley Health

Services Foundation in Athens.

Temporary Certificates Not Valid For Practice Outside Hospital or School

Temporary certificates issued by the State Medical Board under the provisions of Section 4731.291, Revised Code, are solely for educational experience within the confines of the hospital or medical school for which they are issued. Temporary certificates do not allow the practice of medicine outside those institutions.

Section 4731.291, Revised Code, allows the State Medical Board to register, without examination, persons holding either the degree of doctor of medicine, or the degree of doctor of osteopathic medicine and surgery, who wish to pursue internship, residency, or fellowship programs in Ohio. Conditions are:

(1) He is at least twenty-one years of age and is

of good moral character.

(2) He has been accepted or appointed for internship, residency, or fellowship in an accredited program approved by the state medical board in a hospital or medical school situated in this state. The applicant shall indicate the beginning and ending dates of the period for which he has been accepted or appointed.

(3) He is a graduate of a medical or osteopathic school or college which, in the judgment of the board, is reputable and in good standing.

news

(4) He will limit his practice and training within the physical confines of the hospital, hospitals, or facilities for which the temporary certificate to practice is sought.

(5) He will practice only under the supervision of the attending medical staff of such hospital or facility for which the temporary certificate to

practice is granted.

The certificate is valid only for one year, but may, in the discretion of the Board and upon application duly made, be renewed annually for a maximum of five years.

Defense Dept. Changes CHAMPUS Benefits

Several changes to the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) took effect February 28. The changes, directed by the Department of Defense resulted from a continuing study of the program designed to enhance its management and conserve appropriations.

Among the services affected by the changes are enuretic conditioning, orthopedic shoes, megavitamin and orthomolecular therapy in psychiatry, counseling, obesity treatment, stop smoking clinics, plastic surgery,

and modifications to homes.

Enuretic conditioning devices are still a CHAM-PUS benefit but they may be purchased only after the attending physician has done a complete physical examination to rule out organic causes for the enuresis. The devices may be purchased at stores open to the general public, such as retail department stores or catalogue firms. Only the attending physicians will be paid for instruction in the use of the devices. Also, enuresis will no longer be a qualifying diagnosis for coverage under the Program for the Handicapped.

The following are no longer CHAMPUS benefits:

- Arch supports or other mechanical devices to modify shoes or otherwise convert ordinary shoes to orthopedic shoes.
- Megavitamin or other orthomolecular therapy for psychiatric treatment.
- The services of pastoral, marriage, family and child counselors even though the services are prescribed or recommended by a physician.
- Treatment for obesity when obesity is the sole or primary condition being treated. Such treatment would be payable only when it is clearly a part of treatment for another condition that qualifies for payment.

- Plastic reconstructive surgery that is done only to help the psychiatric or emotional needs of a patient. Plastic surgery to correct trauma, congenital defects, abnormal bodily functions or relieve pain is still a benefit.
- Any alterations, modifications or attachment of permanent fixtures to a home or other dwelling as an adjunct to medical care.
- "Stop smoking" clinics and other programs to cut down or stop smoking are not and have never been CHAMPUS benefits.

More information about these changes may be obtained from the CHAMPUS fiscal administrator for Ohio: Mutual of Omaha Insurance Company, 3301 Dodge Street, Omaha, Nebraska 68131.

American Trauma Society Elects Columbus Physician President

The American Trauma Society elected Thomas S. Morse, M.D., of Columbus, President during its annual meeting in Chicago. Dr. Morse is Director of Surgical Outpatient Services, Department of Pediatric Surgery, at Children's Hospital, Columbus.

Headquartered in Toledo, the American Trauma Society is a national voluntary health association which developes programs to prevent injuries and improve care of the trauma patient. The Society, aiming to establish state divisions and county units nationwide, now has 27 chartered state divisions and seven county units, including a Central Ohio-Columbus unit.

Dr. Morse is also Associate Professor of Pediatric Surgery at Ohio State University College of Medicine, and Chairman, Trauma Committee, American Pediatric Surgical Association. He is a member of the Columbus Emergency Medical Services Advisory Council and was named among the top ten men of 1967 in the COLUMBUS CITIZEN-JOURNAL annual newspaper citations.

The Trauma Society was organized in 1971 following a recommendation of the National Academy of Sciences-National Research Council, which called accidental death and disability "the neglected disease of modern society." Accidents are the number one killer of people between the ages of one and thirty-eight and the fourth largest cause of death at all ages.

continued on page 378



Bioequivalence

Poison ivy and other severe allergic states intractable to adequate trials of conventional treatment will often respond to a short, intensive, adjunctive course of Medrol. Medrol Dosepak is designed to provide a tapered, six-day course of methylprednisolone tablets.

On occasion, a six-day course of Medrol therapy may not be sufficient and therapy may need to be extended. If there is continued contact with the sensitizing agent, corticosteroids will not completely suppress the inflammatory response. A further caution: If lesions become infected during Medrol therapy, it should be remembered that steroids may decrease resistance to infection and hinder the body's ability to localize an infection.

MEDROL COMPRESSED TABLETS—2, 4 & 16 MG (METHYLPREDNISOLONE TABLETS, N.F., UPJOHN)

DESCRIPTION AND ACTIONS: Medrol (methylprednisolone) is a synthetic glucocorticoid with potent anti-inflammatory effects. It is readily absorbed from the GI tract. Glucocorticoids cause profound and varied metabolic effects and modify the body's im-

mune responses to diverse stimuli

INDICATIONS: 1. Endocrine Disorders: Primary or secondary adrenocortical insufficiency (hydrocortisone or cortisone is the first choice; synthetic analogs may be used in conjunction with mineralocorticoids where applicable; in infancy, mineralocorticoid supplementation is of particular importance). Congenital adrenal hyperplasia; nonsuppurative thyroiditis; hypercalcemia associated with cancer. 2. Rheumatic Disorders: As adjunctive therapy for short-term administration (to tide the patient over an acute episode or exacerbation) in: psoriatic arthritis; rheumatoid arthritis (selected cases may require low-dose maintenance therapy); ankylosing spondylitis; acute and subacute bursitis; acute nonspecific tenosynovitis; acute gouty arthritis. 3. Collagen Diseases: During an exacerbation or as maintenance therapy in selected cases of-Systemic lupus erythematosus; acute rheumatic carditis. 4. Dermatologic Diseases: Pemphigus; bullous dermatitis herpetiformis; severe erythema multiforme (Stevens-Johnson syndrome); exfoliative dermatitis; mycosis fungoides; severe psoriasis. 5. Allergic States: Control of severe or incapacitating allergic conditions intractable to adequate trials of conventional treatment: Seasonal or perennial allergic rhinitis; bronchial asthma; contact dermatitis; atopic dermatitis; serum sickness. 6. Ophthalmic Diseases: Severe acute and chronic allergic and inflammatory processes involving the eye and its adnexa such as-allergic corneal marginal ulcers; herpes zoster ophthalmicus; anterior segment inflammation; diffuse posterior uveitis and choroiditis; sympathetic ophthalmia; allergic conjunctivitis; keratitis; chorioretinitis; optic neuritis; iritis and iridocyclitis. 7. Respiratory Diseases: Symptomatic sarcoidosis; Loeffler's syndrome not manageable by other means; berylliosis; fulminating or disseminated pulmonary tuberculosis when concurrently accompanied by appropriate antituberculous chemotherapy. 8. Hematologic Disorders: Idiopathic and secondary thrombocytopenia in adults; acquired (autoimmune) hemolytic anemia; erythroblastopenia (RBC anemia); congenital (erythroid) hyperplastic anemia. 9. Neoplastic Diseases: For palliative management of: leukemias and lymphomas in adults; acute leukemia of childhood. 10 Edematous States: To induce a diuresis or remission of proteinuria in the nephrotic syndrome, without uremia, of the idiopathic type or that due to lupus erythematosus 11. Miscellaneous: Tuberculous meningitis with subarachnoid block or impending block when concurrently accompanied by appropriate antituberculous chemotherapy. Systemic dermatomyositis (polymyositis)

CONTRAINDICATIONS: Systemic fungal infections.

WARNINGS: In patients on corticosteroid therapy subjected to unusual stress, increased dosage of rapidly acting corticosteroids before, during, and after the stressful situation is indicated.

Corticosteroids may mask some signs of infection and new infections may appear during their use. There may also be decreased resistance and inability to localize infection. Prolonged use may enhance the establishment of secondary ocular infections due

Since adequate human reproductive studies have not been done, the use in pregnancy, nursing mothers or women of childbearing potential requires that the possible benefits be weighed against the potential hazards to the mother and the embryo or fetus. Infants should be observed for signs of hypoadrenalism.

Average and large doses of hydrocortisone or cortisone can cause elevation of blood pressure, salt and water retention, and increased excretion of potassium. These effects are less likely to occur with the synthetic derivatives except when used in large doses. Dietary salt restriction and potassium supplementation may be necessary. All corticosteroids increase calcium excretion.

While on corticosteroid therapy, patients should not be vaccinated against smallpox. Other immunization procedures should not be undertaken in patients who are on corticosteroids, especially on high dose, because of possible hazards of neurological complications and a lack of antibody response.

The use of corticosteroids in active tuberculosis should be restricted to those cases of fulminating or disseminated tuberculosis in which the corticosteroid is used for the management of the disease in conjunction with an appropriate antituberculous regi-

If corticosteroids are indicated in patients with latent tuberculosis or tuberculin reactivity, close observation is necessary as reactivation of the disease may occur. During prolonged corticosteroid therapy, these patients should receive chemoprophylaxis.

PRECAUTIONS: Hormone therapy is an adjunct to, and not a replacement for, conventional therapy

Dosage should be individualized according to the severity of the disease and the response of the patient. As soon as a satisfactory clinical response is obtained, the daily dose should be reduced, either to termination of treatment or to the minimal effective maintenance dose level. The lowest possible dose should be used and when reduction in dosage is possible, the reduction should be gradual if the drug has been administered for more than a few days. If a period of spontaneous remission occurs in a chronic condition, treatment should be discontinued.

Drug-induced secondary adrenocortical insufficiency may be minimized by gradual reduction of dosage. This type of relative insufficiency may persist for months after discontinuation of therapy; therefore, in any situation of stress occurring during that period, hormone therapy should be reinstituted. Since mineralocorticoid secretion may be impaired, salt and/or a mineralocorticoid should be administered concurrently

There is an enhanced effect of corticosteroids on patients with hypothyroidism and in those with cirrhosis.

Corticosteroids should be used cautiously in patients with ocular herpes simplex because of possible corneal perforation.

Psychic derangements may appear or existing emotional instability or psychotic tendencies may be aggravated by corticosteroids.

Aspirin should be used cautiously in conjunction with corticosteroids in hypoprothrombinemia.

Steroids should be used with caution in nonspecific ulcerative colitis, if there is a probability of impending perforation, abscess or other pyogenic infection; diverticulitis; fresh intestinal anastomoses; active or latent peptic ulcer; renal insufficiency; hypertension; osteoporosis; and myasthenia gravis

Growth and development of infants and children on prolonged corticosteroid therapy should be carefully observed

Blood pressure, body weight, routine laboratory studies, including 2-hour postprandial blood glucose and serum potassium, and a chest X-ray should be obtained at regular intervals during prolonged therapy. Upper GI X-rays are desirable in patients with known or suspected peptic ulcer disease

ADVERSE REACTIONS: Fluid and Electrolyte Disturbances. Sodium retention; fluid retention; congestive heart failure in susceptible patients; potassium loss; hypokalemic alkalosis; hypertension. Musculoskeletal. Muscle weakness; steroid myopathy; loss of muscle mass; osteoporosis; vertebral compression fractures; aseptic necrosis of femoral and humeral heads; pathologic fracture of long bones. Gastrointestinal. Peptic ulcer with possible perforation and hemorrhage; pancreatitis; abdominal distention; ulcerative esophagitis. **Dermatologic**. Impaired wound healing; thin fragile skin; petechiae and ecchymoses; facial erythema; increased sweating. May suppress reactions to skin tests. Neurological. Increased intracranial pressure with papilledema (pseudotumor cerebri) usually after treatment. Convulsions; vertigo; headache. Endocrine. Development of Cushingoid state; suppression of growth in children; secondary adrenocortical and pituitary unresponsiveness, particularly in times of stress, as in trauma, surgery or illness; menstrual irregularities; decreased carbohydrate tolerance; manifestations of latent diabetes mellitus; increased requirements for insulin or oral hypoglycemic agents in diabetics. Ophthalmic. Posterior subcapsular cataracts; increased intraocular pressure; glaucoma; exophthalmos. Metabolic. Negative nitrogen balance due to protein catabolism

DOSAGE AND ADMINISTRATION: The initial dosage may vary from 4 to 48 mg per day. Requirements are variable and must be individualized on the basis of the disease under treatment and the response of the patient. The proper maintenance dosage should be determined by decreasing the initial dosage in small decrements at appropriate time intervals until the lowest dosage which will maintain an adequate clinical response is reached. If after long-term therapy the drug is to be stopped, it is recommended that it be withdrawn gradually rather than abruptly

ALTERNATE-DAY THERAPY (ADT): ADT is a corticosteroid dosing regimen in which twice the usual daily dose of corticoid is administered every other morning. The purpose of this mode of therapy is to provide the patient requiring long-term pharmacologic dose treatment with the beneficial effects of corticoids while minimizing certain undesirable effects including pituitary-adrenal suppression, the Cushingoid state, corticoid withdrawal symptoms, and growth suppression in children

Medrol (methylprednisolone) or other short-acting (producing adrenocortical suppression for 11/4 to 11/2 days following a single dose) corticoids are recommended for ADT. Complete control of symptoms will not be possible in all patients. When considering this mode of therapy, keep in mind the basic principles and indications for corticosteroid therapy. The benefits of ADT should not encourage the indiscriminate use of

SUPPLIED: 2 mg-in bottles of 30 and 100 scored tablets; 4 mg-in bottles of 30, 100 and 500 scored tablets and in 21 scored tablet Dosepak™; 16 mg-in bottles of 50 scored tablets and in 14 scored tablet ADT Pak® (formerly Alternate Daypak®).

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FOR ADDITIONAL PRODUCT INFORMATION, CONSULT THE PACKAGE INSERT OR 1-3748-4 July, 1974 SEE YOUR UPJOHN REPRESENTATIVE.

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Proposed Welfare Billing Systems May Add To Doctors' Paperwork

Claiming that physicians' Medicare-Medicaid paperwork load would increase, the OSMA Committee on Government Medical Care Programs recommended during its April 2nd meeting that OSMA oppose two new systems proposed by the Ohio Department of Public Welfare. The new systems involve the invoicing procedure for cross-over payments and third party payments. The Committee also recommended that OSMA encourage members to become involved in activities of groups that will be establishing Health Systems Agencies under the new National Health Planning and Development Act (Public Law 93-641).

All three of the Committee's recommendations were accepted by OSMA's Council on April 26.

Explanation of Medical Benefits

In March, the Ohio Department of Public Welfare informed OSMA staff that a new system for invoicing welfare patients who qualify for Medicare Part B Coverage had been proposed. In the proposed system, if a physician accepts an assignment, Nationwide Insurance Company furnish the physician with a statement showing their disposition of the claim. This statement is called the "Explanation of Medical Benefits" (EOMB).

The physician would use the EOMB, with added information, to claim payments from the Welfare Department for the unpaid portion of the Coinsurance and Deductible. No payment will be made for Deductibles and Coinsurance where the physician refuses to accept assignment. The Department of Public Welfare would no longer accept EOMB's directly from Nationwide for payment of the claim.

The Committee recommended that OSMA oppose this proposed system since it:

- Forces the physician to take assignment in order to receive EOMB.
- Creates double billing at a very low patient returndollar return.
- Doubles the administrative responsibilities necessary to accomplish billing.
- Makes the physician's office a collecting agency for welfare recipients.
- Possibly reduces the number of physicians willing to take welfare patients by making it more difficult to seek payment.

Payment Sources Other Than Medicaid
The Ohio Department of Public Welfare is trying

to cut Medicaid expenditures by finding welfare recipient's bills which should have been paid by a third party (insurance policy, veterans coverage or other source.) Present invoicing procedures require that a physician's office take reasonable measures to discover any third party resources available to a patient. The welfare department may now propose a new system for investigating third party liability which would increase paperwork for the physician.

The Committee recommended that OSMA oppose making the welfare invoices more complex, specifically in the item of third party payment—other party sources. OSMA believes it is not the physician's responsibility to investigate whether a patient has a third party payment source. Rather, it is the responsibility of the Ohio Department of Public Welfare.

Comprehensive Health Planning

After hearing summary of the National Health Planning and Resources Development Act of 1974 (Public Law 93-641), the Committee recommended that OSMA encourage physicians and medical societies throughout Ohio to become familiar with the law. (Refer to page 283 of The Ohio State Medical Journal's April issue for an analysis of the law.) Physicians are also urged to become involved and active in the Health Systems Agencies.

Two Cleveland Clinic MD's Receive New Posts

Dr. Carl E. Wasmuth, Chairman of the Board of Governors of The Cleveland Clinic Foundation has announced internal staff and organizational changes within the Clinic's cardiac specialties.

The institution's departments of Clinical Cardiology, and Cardiovascular Disease and Cardiac Laboratory have merged into and become sections of a new Department of Cardiology.

Dr. William C. Sheldon has been appointed Head of the new department. A native of Kenosha, Wisconsin, Dr. Sheldon took his specialty training at the Clinic and joined its Staff in 1963.

Dr. Floyd D. Loop has been appointed Head of the Department of Thoracic and Cardiovascular Surgery, to succeed Dr. Donald B. Effler. Dr. Loop took his specialty training at George Washington University and at the Clinic and joined the Staff in 1971. He is a native of Lafayette, Indiana and resides in Cleveland Heights, Ohio.



Former OSMA President Appointed Chairman

Ohio Director of Health Dr. John H. Ackerman has announced the appointment of Dr. Robert N. Smith of Toledo as Chairman of the Comprehensive Health Planning Advisory Council.

In his new capacity, Dr. Smith will head a 39-

member council whose duties include:

 Development of a comprehensive health plan for the state of Ohio, with emphasis on health resources and the delivery of health services;

—Advising the Director of Health on health plan-

ning;

-Reviewing legislation and proposed rules which

could affect public health in Ohio.

Established as a result of federal health planning legislation, the council's members are appointed by the Director of Health with the approval of the Governor. A majority of the members must be consumers. Members serve without compensation, and are reimbursed for expenses.

Dr. Smith has been a member of the council for the past five years and will serve as chairman for the remainder of his seven-year term. A practicing anesthesiologist, Dr. Smith served as president of the Ohio State Medical Association from 1969-1970 and is currently a delegate to the American Medical Association.

AMA-ERF Receives Grant For Primary Care Project

The American Medical Association Education and Research Foundation announced today the receipt of a \$79,475 grant from The Robert Wood Johnson Foundation, Princeton, N.J., to develop a casebook detailing physician-nurse joint practices.

Implementing this nine-month primary health care project will be the National Joint Practice Commission (NJPC), an independent organization established with equal representation from the AMA and the American

Nurses' Association.

Some 25 joint practices throughout the country, featuring primary health care in a variety of settings, will be described in non-technical language in this publication.

According to Shirley Smoyak, R.N., Ph.D., chairperson for the Commission: "Joint practice needs to be studied because of its potential for improving the quality of patient care, expanding the number of patients who can be seen by health practitioners, and developing the new models of collaboration between nurses and physicians."

Physician and nurse practitioners will be interviewed about their collaborative or team approach to patient care. Highlighted in the casebook, scheduled for publication in late 1975, will be non-traditional medical and nursing roles.

Cincinnati Appoints Dr. Leff As Health Commissioner

The Cincinnati Board of Health has named Arnold Leff, M.D. as the city's new health commissioner. Dr. Leff had served as interim health commissioner for the past six months.

Expressing his desire to be a "participatory manager," Dr. Leff said the health board should turn its emphasis from health care to preventive medicine and public health.

It was Dr. Leff's decision that barred approximately 9,900 children from Cincinnati public schools in April because they had not shown proof of legally required immunizations.

A medical graduate of the University of Cincinnati, Dr. Leff is also a member of the Advisory Panel on National Health Insurance for the U.S. House of Representatives' Ways and Means Committee. He is a member of OSMA's Committee on Mental Health.

Orthopaedic Society Seeks Entries For Annual Award

The American Orthopaedic Foot Society has announced that entries of manuscripts are being accepted for the Society's 1976 Albert E. Klinkicht Award.

This award of \$1,000 is made annually by the Society for an outstanding contribution in the field of orthopaedic surgery of the foot and ankle by physicians and scientists resident in the United States or its Possessions.

Problems related to trauma, basic research, or clinical studies will be considered. The paper to receive the award will be selected during the current year for presentation at the Society's 1976 Annual Meeting in New Orleans.

Submission deadline is July 15, 1975. Applicants should submit manuscripts to Nicholas J. Giannestras, M.D., 2415 Auburn Avenue, Cincinnati 45219.

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100 mg. propoxyphene napsylate and 650 mg. acetaminophen



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65 mg. propoxyphene hydrochloride, 227 mg. aspirin, 162 mg. phenacetin, and 32.4 mg. caffeine



Additional information available to the profession on request. Eli Lilly and Company, Inc., Indianapolis, Indiana 46206

500341



Replantation of Amputated Extremities Report of Five Cases

Stanley Jaffe, M.D. A. Scott Earle, M.D. Earl J. Fleegler, M.D. Elias A. Husni, M.D.

Replantation of amputated extremities, including the digits, is now technically feasible and is often successful. For a replantation to be successful, the operative team should be experienced in microsurgery of blood vessels and nerves; and, in so far as possible, in human replantation. Refrigeration without freezing of amputated parts immediately after injury enables replantation to be carried out without haste, but an experienced operating team is essential for complete immediate reconstruction within acceptable operating time.

Editor's Note: With the renewed activity in the use of lawnmowers, shears, and other tools and machines at this time of the year, we commend this article to all physicians.—R.L.M.

Successful experimental attempts to replant amputated extremities in dogs were reported as early as 1903 by Höpfner (who used the term "replantation") from van Bergmanns' Clinic in Germany.¹ In the United States, Guthrie and Carrell were the real pioneers in this field; and Guthrie's monograph, Blood Vessel Surgery, published in 1912, is well worth reading today. He not only reported successful replantations of extremities, kidney transplantations, and a number of other experimental surgical feats, but he also provided a firm foundation on which modern vascular surgery was built.²

A number of surgeons attempted animal replantations during the 1930s; and later, during the 1950s, in well-publicized experiments in Russia. For the most part, these simply reproduced

Carrell and Guthrie's work of 40 years before but, otherwise, added little.

In 1964, Malt and McKhann reported, in a now classic paper, the first successful extremity replantation in a human.³ Since then replantation of extremities has become, if not commonplace, at least feasible and well worth considering in suitable cases. The formation of regional replantation teams and centers have contributed greatly to a success rate which should exceed 50 percent with proper case selection.^{4,5}

Over the past decade, we have attempted replantation on five occasions and have achieved surviving extremities in three patients. This paper reports these cases and comments on the lessons we have learned from them. We will also touch on the preferred steps to be taken if patient referral to a replantation center is contemplated and will examine the indications for replantation. Finally, we will outline briefly the preoperative, intraoperative, and postoperative care that is required to achieve both a viable and a functional extremity.

Case 1.—A 51-year-old right-handed man sustained a guillotine amputation through the proximal carpal bones of the right hand in an industrial machine in August 1965. Oblique amputation of the ulnar three fingers followed as the repeating machine struck again (Fig. 1). Replantation was carried out by an operating team which included a plastic surgeon (S.J.) and a vascular surgeon (E.A.H.). The vessels of the amputated hand were isolated and perfused with heparinized Ringer's solution. Bony fixation was accomplished without bone shortening using large crossed Kirschner wires. One volar and four dorsal veins were repaired. The radial artery required a vein graft for its repair, but the ulnar artery could be approximated end-to-end. The amputated digital stumps were closed. Dorsal fasciotomies were performed in line with the digits. The hand survived without loss of tissue. Two months later, tendon and nerve repairs were carried out. However, this was complicated by partial loss of the index and middle finger apparently secondary to unrecognized arterial compromize. Three further procedures resulted in a prehensile and usable extremity (Fig. 2). The patient continues to work at the same occupation.

Comment: In spite of subsequent partial loss of the fingers on this, our initial replantation attempt, we were able in time to provide a satisfactory prehensile hand of more value to the patient than a prosthetic device would be. We also learned that later surgery may be associated with tissue loss. This is a strong argument for attempting

to perform nerve and tendon repairs as part of the original operation.

Case 2.—In December 1970, a 23-year-old man used a large bread knife to cut off his right hand at the carpal level (Fig. 3). Replantation was carried out with removal of the distal carpal bones, Kirschner-wire stabilization, suture of median and ulnar nerves, repair of extensor and deep flexor tendons to all five fingers, direct repair of the radial artery, repair of the ulnar artery using a segmental vein graft, and anastomosis of five dorsal veins. The hand survived without loss of tissue. Three further reconstructive procedures included tenolyses, wrist fusion, and intrinsic tendon transfers. The end result was an extremely useful extremity (Fig. 4). Unfortunately, the patient committed suicide two years after the replantation.

Comment: This case again demonstrates that a useful extremity can result from a successful replantation attempt. One may question the surgical judgment in carrying out such a procedure on a man with obvious severe mental problems, but, on balance, we believe that the attempt was justified and we would repeat it again given similar circumstances.

Case 3.—A 38-year-old right-handed man was admitted to a hospital in August 1973 after sustaining an automobile "side-swipe" amputation through the left elbow joint and distal humerous. In the accident, the arm apparently had first been crushed over a considerable area and then avulsed. There was extensive tissue loss and destruction on both sides of the amputation site (Fig. 5). Within an hour of the accident, the patient was in the operating room where both the stump and the cooled extremity were debrided. The humerus was shortened and the vessels were perfused with cold heparin and saline solution. Bony fixation was achieved with two in tramedullary Steinmann pins. The brachial artery and the cephalic, basilic, and deep veins were anastomosed

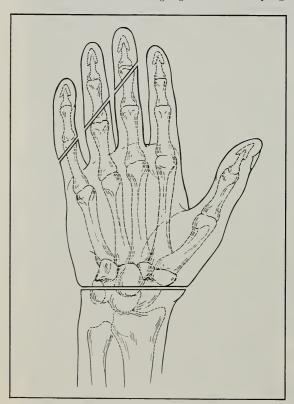


Fig. 1. Level of amputation (case 1).



Fig. 2. Final results in our first patient (case 1).

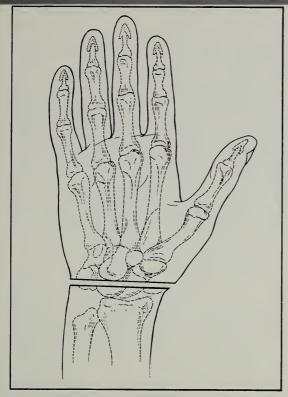


Fig. 3. Level of amputation in case 2.

and circulation reestablished after approximately $4\frac{1}{2}$ hours of ischemia. Skin grafts were required to cover avulsed areas on the extremity. Dextran 40 and aspirin were administered. Postoperatively, the extremity bled continuously and the patient became increasingly toxic with temperature rising to 40.0C (104F). The extremity was removed after 15 hours.

Comment: This extremity, both crushed and avulsed, was a marginal choice for a replantation attempt. The causes of the toxicity and the continuing hemorrhage from the replanted part presumably were the result of incomplete debridement and hemostasis in the damaged extremity. We do not know whether perfusion effected the outcome, but we no longer feel that this is indicated, and it may be deleterious.

Case 4.—In January of 1974, a 53-year-old man sustained a sharp, clean amputation through the midmetacarpal level of the fingers and through the proximal phalanx of the thumb of the left hand (Fig. 6). This occurred at work on an industrial machine (in common with two other injuries in this series). In the operating room, the metacarpals were shortened and fixation was accomplished with Kirschner wires. Eight veins and three arteries were repaired using two power-magnifying loupes. Arterial circulation was marginal from the first and the extremity was clearly lost at 48 hours. It was removed at that time. Coverage of the stump was later obtained with an abdominal pedicle flap.

Comment: This was our first attempted replantation distal to the wrist joint. Although we were aware of the principles of distal replantation, this case made obvious the need for suitable optical equipment, suitable instruments, and intensive laboratory practice if further replantation attempts were to be made distal to the wrist joint.

Case 5.—A 20-year-old right-handed man suffered



Fig. 4. End result in case 2.

a traumatic amputation, in July 1974, through the distal metacarpals of his four fingers and through the metacarpophalangeal joint of the thumb of his right hand in a steel-cutting machine at 1:30 PM (Fig. 7). He arrived at the hospital at 5:10 PM with the hand packed in ice and still attached by a single, frayed flexor tendon (subsequently divided). In the operating room, two teams debrided the amputated ends, isolated vessels suitable for anastomosis, and shortened the metacarpals by 1 cm on each side. The fractures were then fixed with intra-

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Submitted January 2, 1975.

383

medullary Kirschner wires. It was possible to anastomose five dorsal veins and two volar arteries distal to the superficial arch using 4.5X operating loupes. Arterial circulation was established at approximately 9:00 PM. Extensor tendons were repaired, but time did not permit volar tendon or nerve repairs. The postoperative course was essentially uneventful except for a localized hematoma occurring at the suture line at the end of the third week, apparently secondary to anticoagulant therapy. The Kirschner wires were removed after six weeks, and intensive physiotherapy and splinting to overcome joint stiffness were begun. The appearance of the hand at six weeks postoperative is illustrated in Figures 8 and 9. Nerve and tendon reconstruction was begun in December 1974.

Comment: Although this is the furthest distal of any of our major replantations, it was carried out by a team fitted with excellent operating loupes and equipped with suitable instruments. Reestablishment of circulation limited the available operating time so that primary volar reconstruction could not be carried out. Acquisition of operating microscopes and continuing intensive laboratory practice should relieve this problem in future cases.

Discussion

Surgeons replanting a severed extremity think primarily of survival of the part. From the very first, however, function also must be considered. Unless the extremity is more useful than a prosthesis, no favor has been done: the patient will have only an insensate, immobile, nearly useless extremity of minimal cosmetic benefit. Reconstruction should be part of the original operation, but this is not always possible. Lack of replantation

Fig. 5. Diagramatic illustration of amputation in case 3.

experience, intraoperative technical problems, or the patient's condition may all dictate simple salvage initially. A series of reconstructive operations then will follow if the replanted extremity

Today, replantation surgery by a trained team approach is the most acceptable procedure. Our own cases have shown us the need both for proper equipment and proper training if a replantation team is to function smoothly and swiftly. There must be a continuing background of practice in the laboratory on small animals as well as accumulated clinical experience. Unless these requirements are met, the available operating time will be spent struggling simply to achieve a surviving part with no time available for reconstruction of nonvascular structure. Adequate function may be achieved later, but only at considerable expense of time and effort, and optimal function may be impossible to achieve. Proper equipment is an absolute necessity and should include not only suitable loupes, an operating microscope, and microsurgical instruments, but also a number of less obvious items such as instruments for bone shortening and fixation, refrigeration, and double operating set-up.

Clearly not every severed extremity is suitable for surgical reattachment, nor is every patient a

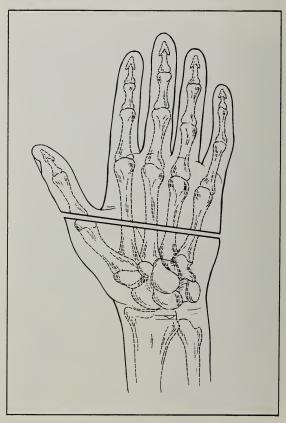


Fig. 6. Level of amputation in case 4.

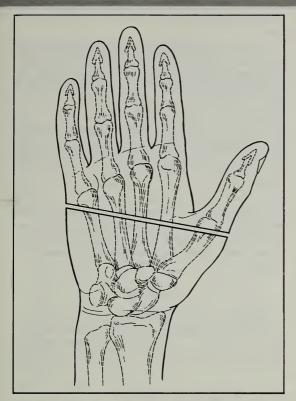


Fig. 7. Level of amputation in case 5.



Fig. 8. Postoperative dorsal view of replanted hand in case 5.



Fig. 9. Postoperative palmar view of replanted hand in case 5.

candidate for operation. Age, medical status, and associated problems including multisystems injuries must be assessed. The patient must desire the operation and should be sufficiently motivated to assure a good result, assuming a successful replantation. At present, we do not feel that our indications can be rigid, for the field of replantation is still too new. We do feel, however, that any patient with a major extremity amputation, amputation of the thumb, or amputation of multiple fingers should be evaluated as a possible replantation candidate.

What of the suitability of the severed extremity or digit? The optimal situation is that of a clean guillotine amputation where there is minimal tissue damage. Crush injuries associated with amputation are commonly believed to be unsuitable for replantation attempts; but, in fact, many will do well given adequate shortening of bone ends and debridement of injured soft tissues. Avulsion amputations have been found to do least well of all. Here vessels, nerves, and tendons are involved by transmitted force over long distances on both sides of the amputation site. Overall, certain amputations from their first assessment obviously will not be suitable for replantation attempts, but in questionable situations, the final decision neces-

sarily must be made by the replantation team in the operating room.

Preparations and Procedure

Time and distance today are seldom barriers to a replantation attempt if proper steps are taken at the outset. The surgeons who will perform the surgery are seldom the ones to provide initial care after injury, yet success depends in large part on the care given the patient and the severed part when first seen. Resuscitation and treatment of shock, tetanus protection, antibiotics, contact with and then arrangement for transfer to a hospital with a recognized replantation team are obvious first steps. The stump should be treated in the simplest manner possible. Major vessels usually do not require ligation; they usually have retracted and are occluded, but an occasional one will require ligature. This should be tied or clipped carefully so as not to destroy length. A simple sterile pad and pressure dressing are then applied.

The amputated part also needs minimal attention, but the type of attention is crucial. First it should be wrapped in a sterile drape. This in turn is placed in a water-proof plastic bag or wrap, and immediately refrigerated by placing it in an ice-filled container (another plastic bag or container; or better, a plastic cooler or camp ice chest when available). The limb should not be frozen! (No dry ice!) It should not be cleaned, disinfected, or debrided. It should not be perfused. As soon as the patient's condition permits, he and the severed part should be transported together to the designated hospital by the most suitable and expeditious means. If this program is followed, one may anticipate successful replantation if circulation can be established within 24 hours of injury.

Once a decision has been made to attempt a replantation, two teams of two surgeons simultaneously prepare both stump and severed part, locating, debriding, and tagging vessels, nerves, and tendons. Skin and other soft tissue are debrided: bone ends are shortened. The operative steps of the replantation itself consist in turn of bone fixation, repair of dorsal veins, tendons, and skin, and finally, repair of the anterior structures. In general, whenever possible, two veins are anastomosed for each artery and more than one arterial repair is carried out. All extremity anastomoses should be carried out under magnification increasing from proximal to distal. We prefer to use 4.5X loupes to the proximal palm, 8X magnification to the base of the fingers, and up to 25X on vessels the size of digital arteries. A suitable operating microscope with zoom control and two (or even three) viewing heads is ideal. Microsurgical instruments are used and monofilament nylon sutures from 8-0 to 10-0 or smaller should be available.

(Suture material is now available to 19 microns in size!)

Early postoperative care approximates that of standard major-extremity surgery, but added decisions may be required; eg, whether and when to anticoagulate; whether "dermotomy" or fasciotomy are required; and, most important, when to reoperate if thrombosis is suspected. Late postoperative care again is similar to that provided after major hand injury. The replantation team should be trained and experienced in all phases of hand reconstruction as late nerve anastomosis, delayed tendon repair and transfer, arthrodeses, and bone grafts may be indicated. The physiotherapists' help is of utmost importance to insure early passive and later active motion, but the patient's motivation becomes the dominant element in achieving the full potential of a replanted extremity.

Summary

Replantation of extremities down to the level of the distal interphalangeal joint in the digits is now technically possible. The primary requirement for success, assuming reasonable case selection, is that of an experienced and properly equipped team trained in microvascular surgery and in replantation techniques.

We have presented our experience with five upper-extremity replantations. Three were successful with the lowest at the distal metacarpal level. These cases have each been discussed as have the criteria of selection, the preparation, and the conduct of a replantation attempt.

Addendum

Since this paper was submitted, we have unsuccessfully attempted the replantation of a totally avulsed scalp in a 20-year-old woman. We have also successfully replanted a thumb in a 60-yearold carpenter.

Acknowledgement: We acknowledge the encouragement and support given by Clifford Kiehn, M.D., Clinical Professor of Plastic Surgery, Case Western Reserve University School of Medicine, Cleveland, Ohio.

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Appendicitis --- Still a Potentially Lethal Disease

John H. Hughes, M.D. Roberta G. Kurtz, Phase III Medical Student

A five-year retrospective audit of management of appendicitis and perforated appendix made at the Medical College of Ohio Hospital, reviewed mortality cases in detail. We found that retarded and disturbed patients, along with infants and the elderly, constitute a high-risk group. We suggest a two-drug protocol for early antibiotic use along with surgery. Continued public education regarding early signs of appendicitis and the sensitivity of our colleagues to recognition of atypical cases should aid in further reduction in mortality from this disease.

Editor's Comment:

The editorial staff of The Ohio State Medical Journal believes that medical students and their faculty teachers should participate in joint presentations of medical scientific manuscripts.

The Journal will be pleased to receive manuscripts coauthored by medical students and faculty and, when such manuscripts are scientifically and journalistically acceptable, will publish them for the benefit of all concerned. We feel that this will make our young colleagues more responsible members of the medical profession in the future.—R.L.M.

WITH INCREASING CONCERN within the profession for reviewing care of common disease entities, the problem of appendicitis has been reviewed at the Hospital of the Medical College of Ohio at Toledo for the years 1969 through 1973. As a new medical school with a selective patient population involving referred complex cases, it was felt that statistics might vary from the norms determined by other reviews. It should be noted that this was a period of transi-

tion when the Maumee Valley Hospital became the Medical College of Ohio Hospital. It was hoped, however, that by reviewing these statistics using basic Professional Administrative Systems (PAS) data, a simple method might be found for meaningful similar reviews in any hospital.

During the five-year period described, a total of 93 patients were seen with a diagnosis of acute appendicitis and 25 patients with a diagnosis of perforating appendix or cecal perforation. Since the mortality from appendicitis is higher in the very young and the very old, the age distribution of our patient group is presented in Table 1. While fever and leukocytosis are indices of infection, in appendicitis, they can be misleading. In our series, 62 percent of those with appendicitis had a preoperative temperature above 37.2 C (99 F), and 84 percent of those with a perforating appendix had similar elevations of temperature. The white blood count was elevated above 10,000/ cu mm in 77 percent of the patients with appendicitis and in 76 percent of those with a perforating appendix (Table 2).

Our statistics showed that 31 percent of the patients with a diagnosis of appendicitis received antibiotics, and 88 percent of the 25 patients with perforating appendix as a diagnosis received antibiotics. It was noted that five patients with appendicitis as a final diagnosis had had no surgery. Review of these records revealed that, in each case, the abdominal pain had rapidly resolved. Two patients with perforating appendix or cecum had had no surgery, and both had died. A wound infection was described in 1 percent of the patients who had an appendectomy for appendicitis and in 28 percent of those operated for perforating appendix (Table 3).

The average length of stay for appendicitis was 6.5 days and the average length of stay for the diagnosis of perforating appendix was 19.2 days. There were no deaths in the category of acute appendicitis, but there were four deaths, representing a 16 percent mortality rate, for the patients who had been categorized as having had a perforating appendix.

This assay revealed that our statistics included patients with either appendicitis with perforation or perforation of the right colon. We chose to keep these cases in our series for examination of the bacteriology and pharmacology involved. The mortality cases of both appendicitis with perforation and right colon perforation, accordingly, are presented in detail.

Case Reports

Case 1.—A 62-year-old obese, white female had noted pain in the right lower quadrant for one week. She was hypertensive and had had previous major

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psychiatric problems. On admission, she was dehydrated, had right lower-quadrant tenderness, and a leukocyte count of 14,600/cu mm. After hydration and intravenous infusion of 2 gm of cephalothin every six hours, an appendectomy was performed. A gangrenous appendix and diffuse peritoneal pus was found which cultured Escherichia coli, anaerobic diphtheroids and three strains of Bacteroides. On the fourth postoperative day, her temperature rose to 39.4 C (103 F), and she developed respiratory distress, and wound dehiscence. Laparotomy was performed following the evisceration, but hypotension developed followed by cardiorespiratory failure and

At autopsy, there was evidence of generalized peritonitis and septicemia, marked gastric and intestinal dilatation, and a mucus plug in the carina. Cultures from the peritoneal cavity grew Pseudomonas and E.coli.

-A 77-year-old, 185-lb., diabetic woman had had dull abdominal pain with nausea and vomiting for three days. At the time of admission, she had abdominal pain and tenderness in the right lower quadrant with a suggestion of a mass, both by physical and radiologic observation. Her leukocyte count was 22,000/ cu mm with shift to the left. Her electrocardiogram showed evidence of an old, inferior, myocardial infarction with ST changes from probable anterolateral ischemia. Physical examination also revealed hemiparesis from a previous cerebrovascular accident. After two days of hydration and antibiotics, the patient underwent a laparotomy with findings of a perforated retrocecal appendix with gross contamination of the peritoneal cavity. Cultures of the peritoneal fluid showed Pseudomonas aeruginosa and E.coli.

Immediately following surgery, she was found to be in renal failure. This was then followed by pulmonary failure and congestive heart failure. She received Digoxin,® Mannitol,® and then Lasix,® but she died on the fifth postoperative day. Permission for autopsy was not obtained.

Case 3.—A 90-year-old white female had resided at a local county home and had complained of pain in the abdomen for two to three weeks. She had been hospitalized elsewhere four months previously with a diagnosis of a tumor involving the right colon, but she refused surgery. At this time, the patient presented with pain in the right lower quadrant; she had a temperature of 37.9 C (100.2 F), and white blood count (WBC) of 10,700/cu mm with left shift. The patient received intravenous fluids and cephalothin. The family physician and the family together refused any surgery for this patient and she died.

At autopsy, the patient was found to have an adenocarcinoma of the pancreas involving the right colon, with a perforation 5 cm above the cecum with gross peritonitis.

Case 4.—A 68-year-old white female, who lived with her 39-year-old retarded daughter, was found lying on the floor at home. She was believed to have been lying there for over three days. At the time of admission to the hospital, she was afebrile, had no abdominal pain or tenderness, her hemoglobin level was 14.2 gm/100 ml, and leukocyte count was 8100/cu mm, with slight shift. During her hospital course, ampicillin was given for a proven urinary-tract infection.

Nine days after admission, the patient developed abdominal pain while being treated for apparent starvation. Sigmoidoscopy and barium enema revealed no abnormalities, although the right colon was not well visualized on x-ray film. By the 11th day, the patient had a mass in the right lower quadrant. Although afebrile before, at that time, her temperature went to 37.3 C (99.2 F). Her leukocyte count was elevated to 17,600/cu mm with marked shift. Paracentesis showed gross fecal material. The patient rapidly went into renal failure and died before operation.

Autopsy examination showed a perforation of the cecum in the anterior wall and a normal-appearing appendix. Cultures from the peritoneal cavity grew E.coli and Enterobacteriaceae.

Pharmacology and Bacteriology

The clinical records of these four cases were reviewed in terms of pharmacology and bacteriology. All four of these patients had been given a broad-spectrum antibiotic upon admission. In case 1, three organisms were isolated from the peritoneum during appendectomy. They were sensitive to the cephalothin being given. When complications developed on the sixth day, carbenicillin and erythromycin were added to the treatment. The autopsy cultures grew Pseudomonas and E.coli. Although the dosages used were felt to be within therapeutic range, a more vigorous antibiotic effect against Pseudomonas might have averted the gram-negative septicemia which de-

In case 2, ampicillin was given initially with cephalothin added after the appendectomy. Although the patient's clinical course was immediately complicated by renal failure and progressive pulmonary and congestive heart failure, the culture and sensitivity results of the peritoneal fluid indicated that only one of the two organisms was sensitive to the drugs given.

In case 3, the patient with carcinoma of the pancreas and right-colon perforation received

TABLE 1. Age Distribution of Patients

Diagnosis	No. of Patients	Under 13 Years	14 to 16 Years %	Over 65 Years %
Acute apper	ndi- 93	26	72	2
Perforating appendix	25	28	40	32

Table 2. Preoperative Temperature and White Blood Cell Count (WBC) of 93 Patients

	Temperature Over 37.2 C (99 F)	WBC Over 10,000/cu mm	
Diagnosis	%	%	
Acute appendicitis	62	77	
Perforating appendix	x 84	76	

TABLE 3. Factors in Treatment and Results

Diagnosis	Antibiotics	Surgery	Wound Infection
Acute appendicitis	31	88 of 93 (all but 5 whose pain resolved	1
Perforating appendix	88	23 of 25 (all but 2 who died)	28

cephalothin throughout the hospital course. No culture results were available.

In case 4, urine cultures grew *E.coli*, sensitive to ampicillin which was started on the third day. The abdominal symptoms appeared late, with renal failure and subsequent death occurring before surgery could be undertaken. At autopsy, cultures revealed two organisms, both resistant to ampicillin.

By retrospective review, it appears that more vigorous antimicrobial therapy was indicated. The potential for gram-negative septicemia from a perforating appendix requires broad-spectrum antibiotic coverage with special coverage for gramnegative organisms. The most common organisms isolated in our cases were similar to those obtained in the series recently published by Gilmore and Martin¹ (ie E.coli, Klebsiella, Pseudomonas, Bacteroides, Staphlococci, and Streptococci).

At this point, there seems to be rational basis to recommend the early use of two antibiotics in cases of suspected ruptured appendix. Table 4 reflects the opinions of the staff of the infectious disease unit at the Medical College of Ohio at Toledo for choice of antibiotics for the most frequently encountered organisms.

Discussion

Since the symptoms of nonperforated appendicitis were first described by Charles McBurney in 1889,² early appendectomy has become increasingly more popular. The mortality from this disease has been reduced markedly during the period of development of effective antibiotics and advances in medical management. Butsch, et al³ quote a present mortality rate in the United States of 1,500 cases a year. Allen⁴ has suggested that education of the laity and the medical profession to early surgery for appendicitis has been the largest factor contributing to a reduced mortality rate. Since this death rate is still quite significant, continued education is essential.

As the diagnosis is more difficult to make in infants and the elderly, mortality in these groups is clearly higher. Our series points out that emotional disturbances and concurrent severe medical illnesses also may contribute to mortality. Our statistics again confirm that one cannot depend upon fever or a leukocyte count to make a diagnosis of appendicitis, as reported by Lee⁵ and others, and that high suspicion of the atypical case of appendicitis is warranted.

In review of such cases, one must be aware of host defense factors as well as bacteriologic invasiveness along with the actions of both surgery and antibiotics. An atypical location may lead to delayed diagnosis. Accordingly, more extensive tissue necrosis and perforation may develop prior to surgery. Inflammatory spread may be walled off by omentum and other organs. While host

TABLE 4. Antimicrobial Drugs of Choice

First Choice	Second Choice
Ampicillin/ Gentamicin	Gentamicin with Cephalosporin
Gentamicin with Carbenicillin	Polymyxin with Carbenicillin
Erythromycin	Clindamycin Chloramphenicol
Gentamicin	Kanamycin Polymyxin
Gentamicin with Cephalosporin	Kanamycin Polymyxin
	Ampicillin/ Gentamicin Gentamicin with Carbenicillin Erythromycin Gentamicin Gentamicin with

leukocyte and antibody responses are significant factors in control of infection, a rapidly spreading peritonitis of bacteria and foreign-body fecal material in the peritoneum with concurrent sepsis are much larger factors. Retrospective analysis once again points out the value of an aggressive physiologic, pharmacologic, bacteriologic, and surgical approach to the patient with a perforating appendix.

Conclusions

Retrospective analysis of a simple disease entity such as appendicitis can be meaningful in any hospital. Comparative studies, however, may be biased by selective patient populations. Early appendectomy, along with intensive and appropriate use of antibiotics with skilled team management, are essential to the treatment of patients with a perforating appendix. The early diagnosis of the atypical case of appendicitis will enable our colleagues to better care for the patients suffering from this disease entity.

A two-drug protocol for the early antibiotic management, based on culture and sensitivity studies from our institution, is suggested.

Acknowledgment: Mrs. Cheryl Heider, Health Record Analyst of the Medical College of Ohio Hospital, and Earl Freimer, M.D., Director of Infectious Disease Section, Medical College of Ohio Hospital, assisted in the compilation of data for this paper.

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Maternal Mortality Report for Ohio — 1972*

By the OSMA Committee on Maternal Health

YOUR COMMITTEE on Maternal Health proudly presents this EIGHTEENTH annual summary of its research and educational program for the year 1972. The report is published to comply with a directive creating the Committee, establishing its functions, and subsequent follow-up action taken by The OSMA Council, January 16, 1954.1

The first portion of this report outlines activities of your Committee since its last report to Council on July 28, 1974.² The second part mentions several projects developed by the Committee and relating to its assigned functions, while the third division contains a detailed statistical analysis of maternal deaths for 1972 gleaned from The Ohio Study. All maternal deaths in the 88 Ohio counties are covered.

The fourth part contains a summary and discussion of the data, while the fifth section presents *recommendations* from your Committee, based upon its experiences with "Maternal Health in Ohio."

Activities

As reported previously,² the Committee presently consists of 20 members, representing the 11 OSMA Councilor Districts geographically. In the profession, these represent talent from the family physician as well

as the specialties, eg, obstetrics and gynecology, anesthesiology, internal medicine, and pathology.

The 60th meeting of the Committee (as the Committee was 21 years old) was held January 18 and 19, 1975 at the Granville Inn, and was very successful. A distinguished guest, Dr. Antoinette Eaton, newly appointed Director of the Ohio Department of Health, Division of Maternal and Child Health, presented some of the current problems in the maternal health field and pledged a continued liaison between her office and members of our Committee in an advisory capacity.

Forty-six maternal cases were studied and classified by the Committee using "Guiding Principles" as a standard for ideal care. Furthermore, members revised this document for the third time during the year to bring it "up to date."

Answering a request from the Council, the Committee reviewed, and studied past and present standards of obstetric anesthesia, and finally developed a recommendation to *interpret* the phrase, a "prescribed course" in anesthesia (Sec. 4731.35 Ohio Code, revised). After the Council considered the recommendation, it was referred to the State Medical Board for consideration; and on December 3, 1974, the interpretation was adopted by the Board.

Several Committee members have participated in conferences of an Ad Hoc Committee to improve patient care related to abortions in Ohio; thus, the Ad Hoc Committee represents District V, the American College of Obstetricians and Gynecologists (ACOG), the Ohio Department of Health, and the OSMA.

In Columbus, on March 5-6, 1975, the Chairman represented the OSMA at a seminar and intraprofessional workshop on drug use and abuse sponsored by the U.S. Department of Justice, Drug Enforcement Administration.

^{*}A continuous statewide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association in cooperation with the Ohio Department of Health and representatives of the various County Medical Societies. Summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published here from time to time, interspersed with statistical summaries.

Projects

The Committee's column, "Maternal Health in Ohio" continues to appear in The Ohio State Medical Journal on a quarterly basis. Recently, under advice of the Council and the Consulting Medical Editor of The Journal (Dr. Richard L. Meiling), the format for presentation of cases was altered to a narrative consideration of disease entities. It is hoped that this will develop more concern and interest on the part of our many readers.

Currently, an exhibit prepared by the Committee on Maternal Health Health is ready for display (Booth S-424) during the OSMA Annual Meeting to be held May 12-14, 1975 in Columbus. It involves Ohio statistics for 18 years, and includes a "cartoon" for "Ideal Obstetric Care."

Our most extensive project is now completed. As previously reported,3 the immense, complex task involving transcription of case data from IBM cards into computer-oriented formats has been accomplished without cost to the Committee's budget, or to the OSMA. The Chairman has worked with statistic data-processing experts of Ohio Medical Indemnity, Inc. to make the data on each of the 1656 cases in our files more readily available for numerous research and educational programs. Statistics published below represent the first products of this unique project.

According to established custom, the following statistical survey is published using uniform nomenclature and terminology prescribed for the Committee since 1954. They follow closely those used for The International Classification, and definitions recommended by the AMA, and the ACOG.

Ohio Maternal Mortality Study Statistics for 1972

Statistics for 1074
Total Live Births in Ohio, 1972
Total Cases Studied (1972)
Undetermined 0
Maternal Deaths (Classifed)
Non-white 8
White 16
Age:
Teens 4
20s 13
30s 5
40s 2
Parity:
Primigravidae 8
Multiparae 10
Unknown 6
Place of Death:
Hospital
Home 5
Other 1
Type of Delivery:
Not Recorded 0
Operative (2 ectopic)
(- F
Not delivered 6

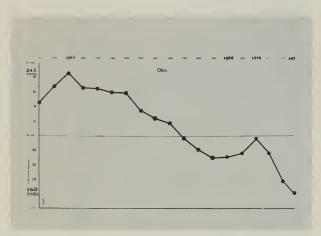
Route of Delivery: Not recorded	0 9 7	
(antemortem)	0	
Laparotomy (ectopic preg.)	2 6	
Not known	0	
Group II (fr. 20th wk. to 28th wk.)	2	
Group III (fr. 28th wk. through term) Group IV (postabortal, postpartum) Autopsies	17 15	
(includes 5 coroners' cases) Prenatal care (apparent from data sheets):		
None Unknown or not reported	3	
Adequate	10 4 6	
Classification of Principal Causes of Death:	U	_
Hemorrhage Abortion, without sepsis Abruptio	0	5
Afibrinogenemia	0	
Am. fl. embolus 0 Dead fetus 0		
Ruptured uterus 0 Atony, uterine, postpartum	1	
Ectopic pregnancy (without sepsis) Laceration, extrauterine	2 0	
Placenta praevia Retained placenta Ruptured uterus (no afibrin.)	0 0	
Other		5
Abortion, septic, induced	0	
Up. resp. inf. Peritonitis Prodonophaitie	0 3 0	
Pyelonephritis Septicemia (puerperal sepsis) Septicemia (other)	0 2	
Other	0	3
Acute yellow atrophy	0	J
with cerebrovascular hem.)	0 3	
Preeclampsia	0	
Other		11
Anesthesia 1 (general) 1 (regional) 1	2	
Cardiac disease	3	
Chorioepithelioma	1 0	
Lower nephron-nephrosis	0	
Pulmonary embolus	4 0	
Other High Risk "OB" patients (41.2 percent)	0	10
(41.2 percent) High risk condition related to cause of dea (20.8 percent) (conti		5 (d)
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There were 169,151 live births reported in Ohio during 1972.⁴ From this maternal mortality study, the Committee classified 24 maternal deaths for the year. The maternal mortality rate was 0.14 per 1,000 live births, or 1.41 per 10,000 live births for 1972.

Through its members, the Committee maintains close liaison with the *six* well-established county maternal death studies of Ohio. These studies in metropolitan areas operate on an annual basis, sponsored principally by the obstetric-gynecologic societies of Cleveland, Columbus, Cincinnati, Dayton, Toledo, and Akron, respectively.

Discussion

Again, we are impressed with the decrease of 20,768 live births in Ohio, from 1971 to 1972.² More astonishing is the fact that the number decrease is identical to the figure representing a similar decrease from 1970 to 1972. (See figure.) However, the maternal mortality rate for 1972 (1.41 per 10,000) is decidely lower than



Number of live births in Ohio per year for 19 years (1955 through 1973).

the rate for 1971 (2.21). This is obviously due to the fact that the records of some maternal deaths were overlooked or that our obstetric techniques have improved! We have reason to believe it is the latter!

Six of the 24 patients died undelivered; four were "teenagers." Autopsies were performed upon 15 (62.5 percent) of the patients; five of the 15 were coroner's cases. Once again, hemorrhage and infection vie equally in "HIT" (hemorrhage, infection, and toxemia) causes of death while pulmonary *embolus* leads the "other causes." The Committee found that nearly half of the patients were *High Risk* obstetric patients before pregnancy; in five (20.8 percent) of these, the cause of death was related to the High Risk condition.

Recommendations

1. Again, the Committee recommends that the Ohio Maternal Mortality Study be continued and

supported in all of its educational and research facets within the limits of available financial resources.

- 2. Members of the Council are respectfully requested to directly assist the Committee in its program in *two* respective avenues:
 - A. Encourage local county medical societies to organize (small) committees on Maternal Health with the idea that such groups can assist in "culling out" or identifying local maternal deaths. By referring such cases to the regional (state) committee members, less cases will escape proper identification and study.
 - B. The OSMA should sponsor the introduction of proper legislation to provide for the protection of confidentiality and the legal immunity of material in the Ohio Maternal Health Study and other professional research projects. The States of Minnesota, Michigan, California, Massachusetts, and Nebraska have already established such necessary laws.

3. Liaison with the Ohio Department of Health will be continued, especially with the Division of Maternal and Child Health. It is hoped that efforts to collect data on maternal death cases will continue to improve.

4. With the improved technology in computer-processing of data in our cases, Council and Committee members are invited to participate in the expansion of our educational program. Through this matured program, we will improve "Maternal Health in Ohio" and contribute to one important aspect of a "Quality of Life" program.

The Chairman, with sincere gratitude, acknowledges the support of Committee members who discharged their duties efficiently during the reporting period.

On behalf of the Committee, the Chairman recognizes the interest and cooperation of the Council, attending physicians, representatives of numerous county medical societies, the Ohio Department of Health, Ohio Coroner's Association, and many other individuals and agencies, particularly personnel of the computer section, Ohio Medical Indemnity. With their continued cooperation and assistance, this Ohio Study has continued to progress.

Respectfully submitted, Anthony Ruppersberg, Jr., M.D. Chairman, Committee on Maternal Health

Approved by the Council of the Ohio State Medical Association, April 27, 1975.

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Foreign Medical Graduates

Representatives from private and government sectors grappled with the complex and controversial Foreign Medical Graduate (FMG) problem during a recent conference in Washington D.C.

The conference, co-sponsored by the Coordinating Council on Medical Education, the Educational Commission on Foreign Medical Graduates, and the National Council on International Health, made the following recommendations:

- That duration of graduate medical education in the United States of all exchange visitor physicians be specified in advance and, in general, limited to two years or less.
- That federal funds be authorized to support the nationally coordinated graduate medical education program for exchange visitor physicians.
- That sponsorship of FMG's as exchange visitor physicians be limited to accredited U.S. schools and teaching hospitals.
- That U.S. medical schools expand their use of COTRANS (Coordinated Transfer Application System) to facilitate the introduction into American medical education of qualified U.S. citizens enrolled in foreign medical schools.

Foreign Medical Graduates (FMG's) are divided into two groups: 1) U.S. citizens studying medicine in non-U.S. or Canadian Medical Schools and 2) non-U.S. citizens entering the United States with a degree in medicine.

Originally, non-U.S. citizens with a medical degree entered the United States under the provisions of the "visitors exchange program." This program allowed the FMG to receive training in the U.S., but compelled him to return to his native land afterwards. Approximately 4,000 of the 8,000 FMG's entering this country annually are in this program. However, 80 percent of the 4,000 FMG's remain permanently in the United States.

The U.S. Department of Labor currently operates under a blanket policy that medical and health professionals are in short supply in the United States. As a result, the Department gives almost automatic permission to physicians seeking admission as permanent residents. Either the Department of Labor must change its regulations or Congress must enact legislation to affect the needed change.

House Staff positions will be filled largely by domestic medical school graduates in the next three to four years thanks to expanded medical school enrollment and graduation.

The proposed "Health Manpower Act of 1975" (H.R. 2956, Rogers, D.-Fla.) is similar to the 1974 bill which passed both houses. Should this bill become law, the current annual influx of FMG's would be eliminated.

If the conference's proposals are followed, the State Department would be responsible for issuing the limiting visas. This may very well correct the Department of Labor's blanket policy which is now in effect.

Richard L. Meiling, M.D.

The 93rd Congress

Do you ever wonder what Congressmen and Senators do when in Washington D.C.? During the 93rd Congress (1973-74), more than 21,000 bills were introduced. Only 650 survived the full legislative process—committee hearings, amendments, floor debate, joint committee compromise, final vote, Presidential staff review, and Presidential veto or signature—and became law.

AMA Taking Economy Measures

Economy and controlled fiscal policy is being followed at AMA Headquarters. Dr. James H. Sammons, Executive Vice President, announced on May 2, 1975 a staff reduction of 77 people. The payroll at the end of the last (fiscal) year (November 30) was 932. Currently it is 824.

This responsible fiscal and management program warrants each AMA member sending the 1975 assessment of \$60 to AMA Headquarters immediately. Approximately 124,000 members have done so. What about you?

Coding Diseases & Problems

How and Why You Should Be Using Problem Oriented Medical Records

Douglas P. Longenecker, M.D.*

RCGP, ICD (International Classification of Disease), HICD (Hospital International Classification of Disease), CPT (Current Procedural Terminology), PSRO — oops, sorry about the latter set of initials, but "PSRO" seems to be included in every list of initials!

Physicians in all areas of specialization are today beseiged with initials indicating a separate, specific taxonomic classification. Add to this confusion the myriad of numbers — Category 2, Category 18, 158, 172, 381.0, 281.1, etc., and it's easy to see the coding of diseases, problems, and/or procedures is enough to cause any actively practicing physician to say—the h - - with it. This attitude isn't entirely unreasonable, but there are some very valid reasons for employing a coding procedure in an ambulatory setting.

Added to the confusion that can easily exist with initial abbreviations and the numerical maze is the problem of mechanics and time.

Now I'd like to switch in topic from coding to problem oriented medical records (POMR) for two reasons. First, mechanics and time are a common denominator when discussing both office coding and office POMR's. Secondly, in order to be able to employ any selected code classification of disease, the physician must have the ability to easily identify and recall the diagnosis, problems, or procedures to be coded.

The problem oriented medical record in its most complete form¹, and modifications², to perhaps individual physician adaptations³, is a very beneficial concept and tool which assists in the practice of medicine and consequently, improves patient care. In spite of this acclaim, very few practicing physicians employ the POMR in their offices, continuing instead their source oriented medical records.

Resistance to POMR

Many arguments are presented as reasons for not utilizing the POMR system, but two of the more frequently encountered are: (1) "How do I switch 5,000 patient records to the POMR system?" or (2) "My girls and I don't have time to recopy 5,000 medical

records." Add the problem of selecting an appropriate POMR format, cost of involvement, incomplete understanding of the system, plus innumerable other factors, and one can easily understand practicing physicians' reluctance to rush out, buy, and then implement a POMR system.

Both of these very valid reasons for hesitancy must be considered in more detail. Perhaps if the practicing physician could utilize a mechanism for ease in identification of codeable areas, a major part of the resistance and objection could be eliminated. The application of only one aspect of the POMR format could resolve the identification difficulty — the initiation of a "Problem List" for each medical record.

The mechanics to do this must be individualized for physician and office. One mechanism could be employed when patients return for an office visit. As the physician is searching through the medical record to refresh his (her) memory as to previous problems, diagnosis, medications, etc., the problem list could be made, or at least a "flagging" procedure used. Therefore an aide could produce the problem list before the record is re-filed. This "prolonged" or similar method of implementing a problem list would indeed take a certain amount of time, but would eliminate the "weeks" necessary to convert all office medical records at once to either the POMR format or to source-oriented medical records with a problem list. As mentioned earlier there are innumerable methods to institute either the problem list or total problem orientation. However, this article's intent is not to explore all these possibilities, but rather attempt to point out the eventual advantages of coding.

Selecting a Code

Assuming the ability for identification and recall has been solved by any appropriate method, the physician must now face the grim reality of interpreting both the alphabet maze and the number mass.

The University of Rochester School of Medicine and Dentistry and Highland Hospital have developed their E Book adaptation of the Royal College of General Practice Classification (RCGP remember?)⁴. This E Book has received not only wide recognition but also

^{*}Dr. Longenecker is Associate Professor and Chairman of the Department of Family Practice at Wright State University's School of Medicine, Dayton.

successful employment in both Family Practice teaching programs and private offices.

Various codes can be mentioned to establish the concept that at the present time, the specific selection of a code is perhaps less important than the ability to utilize the code with facility in an everyday office practice. To elucidate, the International Classification of Disease (ICD) utilized categories and sub-categories that number in the thousands. The Rochester Modification of the Royal College of General Practitioners (RCGP) contains twenty two sections with less than a thousand categories. It is obvious that deciding between these two classifications will depend on many factors, but the "numbers" game cannot be overlooked. Once a specific code has been selected and a card file or similar format established, a cross reference system can be utilized if a new classification or code is subsequently adopted.

"Assuming the ability for identification and recall has been solved . . . the physician must now face the grim reality of interpreting both the alphabet maze and the number mass."

Hopefully a small amount of insight has been provided into the "how," or at least sufficient stimulation to encourage some practicing physicians to initiate a more detailed investigation into a coding mechanism.

Why Should You Switch?

Now, what about the "why"? It is here, in my opinion, that the real significance lies. How many times, when a new procedure or therapeutic modality became available, have you had to search in vain to identify all the patients in your practice who could be benefited? Have you ever questioned how many diabetics, hypertensives, post-coronaries, post-strokes, TIA's, etc., you have seen in the last month, year or decade? What about your method of managing all your patients with a single

disease entity or problem. Do you utilize one overall approach or does the management regimen vary with each patient? Why? Is the care of all your patients with a specific problem more beneficial now than one year ago, five years ago, or ten years ago? Can you easily identify, for recall study, patients in a high risk category that should be reminded periodically for re-evaluation? If you are a Diplomate of the American Board of Family Practice, can you easily and rapidly locate the specific patient records necessary to submit to the ABFP for the recertification process?

If you can honestly answer in a positive manner to the above questions as well as a myriad more, I apologize for wasting your time by preparing this article which you "unfortunately" took the time to read. On the other hand, if you cannot answer these questions in a positive manner, perhaps there has been a valid reason proposed for you to look into the establishment of a "disease index" for your office. Disease index is the term used for the card file, etc., containing the coded data indexed by disease, number and category.

The actual transfer of the coded data from the medical record to the disease index is another area that, by necessity, should be individualized for each office and physician. The end result is the ability to personally open the disease index (or have an aide do this), and locate the specific problem in question, find the name and other pertinent data of all your patients included in this category. Again, depending upon the design you have chosen, you may need to refer to the office medical record for more detailed information, but at least you will know which records need to be surveyed.

It is my honest opinion that, even though the above described effort is significant, the rewards gained by both the physician and his (her) patients will be infinitely greater.

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How A Bill Becomes A Law.

One of the more complex aspects of the legislative process is the procedure by which a bill becomes a law in Ohio. It is especially important for physicians to understand this process since much state legislation directly affects them. H.B. 682, the omnibus malpractice bill supported by OSMA, is an excellent example. On the next few pages The Journal outlines how the legislative process works and where a bill can fail. Also included is a legislative directory, complete with instructions on writing your local legislator.

How a Bill Becomes a Law

INTRODUCTION OF BILLS: All proposed changes to Ohio laws are called bills, until enacted by both Houses of the General Assembly. Bills are introduced in type-written form by any member of the Senate or House of Representatives. A regular order of business provides for their introduction. Upon its introduction, a bill is given a number and read for the first time, by title only. From here on the bill will be identified only by number and author.

SECOND READING AND REFER-

ENCE OF BILLS: In the House the bill then goes to the Reference Committee which considers the bill both as to form and substance and reports back to the House the standing committee to which the bill is assigned for hearing. The reading of this report constitutes the second reading of the bill. In the Senate a regular order of business is provided for second reading and at this time committee assignments are made by the Chairman of the Select Committee of Reference. In both houses the bill is normally ordered printed at this time.

COMMITTEE HEARING: Hearing by a committee is the most important step in the legislative process, for it is in committee where the fate of a bill is usually determined. It is

in committee that a bill is passed as introduced, amended, tabled for later consideration, or killed. During the 111th General Assembly, 11 Senate committees and 18 House committees will decide upon the many bills introduced.

THIRD READING: After a bill had been reported favorably by a standing committee, the Rules Committee of both the Senate and House of Representatives, acting as a Calendar Committee, designate which bills shall be considered for passage and on what date. At the designated time those bills selected are called up for a third reading. At this time the bills are debated on the floor, may be amended on the floor, and are finally voted upon by the membership. In the Senate this is done by a voice vote in answer to a roll call. In the House, because of its larger membership, an electric roll-call system is used and the members indicate their vote by means of a switch. The individual and total vote is shown on large indicator boards. A majority vote of each house is required to pass the usual bill, although certain appropriation measures and emergency legislation require a two-thirds vote of the membership. Following passage of a bill in the house of its origin, it must follow the same general procedure in the second house.

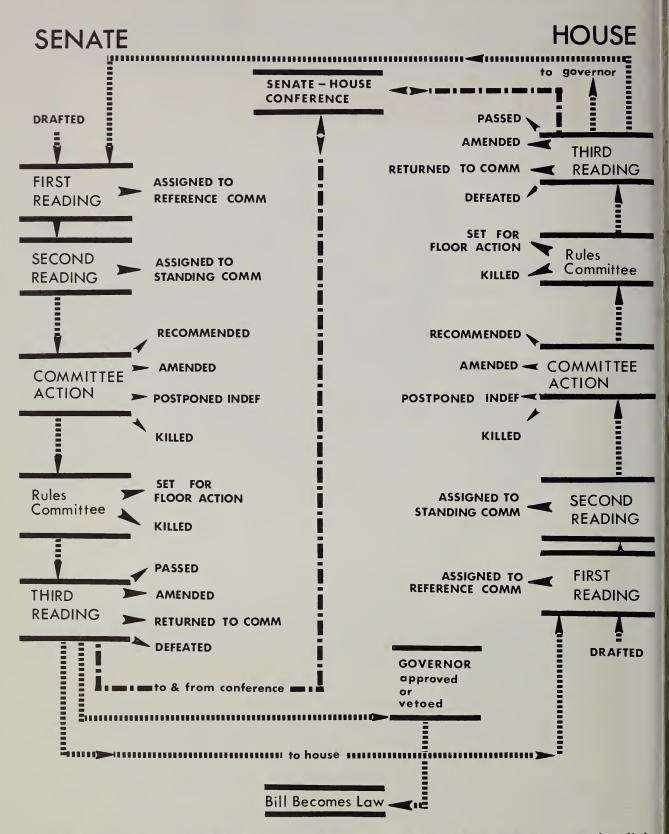
AMENDMENTS: If the bill approved by one chamber is then amended by the other, the amendment(s) must be agreed to by the

first chamber before the legislative process can be completed. Should the first chamber refuse to give its consent, a conference committee is appointed to work out a version of the bill that will be satisfactory to both houses. Once this has been accomplished, the bill goes to the governor for his signature.

AN ACT: After a bill has been passed by each house, it is then enrolled in act form, signed by the presiding officers of each house and presented to the Governor for his consideration.

step in the enactment process is for the governor to sign the bill, veto the measure (he sends it back to the house of origin with his veto. If three-fifths of the members of each house vote to pass the measure notwithstanding the Governor's objections, it becomes law in the same manner as if the Governor had originally approved it) or if the Governor simply refuses to sign the bill for a period of ten days from the time it is presented to him, it automatically becomes law.

the Governor approves the particular legislation, it is signed and filed with the Secretary of State and the act normally becomes effective 90 days after such filing. The effective date, however, for emergency bills, tax levies and appropriation bills is earlier. Also a bill may specifically provide for an effective date later than 90 days after filing.



The above diagram outlines the steps a bill takes through the Ohio Legislature, from the time it is drafted until it becomes a law. Note that a bill may be introduced in either house. Also note the many steps at which a bill may be killed.

How a Bill Fails

MORTALITY RATE: On the average, a bill is more likely to fail than to succeed. During the 110th General Assembly (January, 1973 through 10 December, 1974) a total of 591 bills were introduced in the Ohio Senate, with 212 being passed by that body, and 166 presented to the Governor for his signature. There were no Governor vetoes. A total of 166 passed Senate bills became law. On the House side a total of 1479 bills were introduced, with 338 passed by that body. Of the total passed 237 were sent to the Governor for his signature. The Governor vetoed one measure and the remaining 236 became law.

Generally speaking, a bill will fail for one of three reasons. (1) The bill lacks intrinsic merit to the point of failing to gain any support. (2) The bill attracts powerful opposition or generates strong disagreements. (3) The bill gets stalled somewhere in the legislative machinery and fails to regain momentum in time to be enacted. Following are some specific ways in which a bill can die.

INTRODUCTION: Either house has the authority to vote not to receive a bill on its introduction. (Right of Rejection rule).

COMMITTEE ACTION: The committee to which a bill is referred can kill it simply by refraining from acting on it. The bill can eventually be forced out of committee through bringing the issue before the entire legislative body, but this rarely occurs.

SECOND READING: A motion for indefinite postponement sometimes is made from the floor at this point in the process. Attempts also may be made to amend the bill in such a way that it will stand less chance of passage. Or a motion may be made to strike out the enacting clause which, if successful, causes the bill to be emasculated.

THIRD READING: A bill can win approval of more than half the legislators voting on it and still falter at this point through failure to gain a constitutional majority—meaning 50 "aye" votes in the House of Representatives or 17 "Aye" votes in the Senate. A bill which has simply failed to win a constitutional majority can be called up again for another

How to Write Your Legislator

With thousands of separate pieces of legislation to consider every year, legislators at Columbus need the opinion, advice, and specialized knowledge of their constituents to guide them. It is impossible for any legislator to have detailed knowledge of the technicalities of every bill which he must consider. This means that the legislator welcomes your letters, even if you oppose a bill, because you are providing him with knowledge he needs to make a decision.

Because every legislator considers a large number of bills on a wide range of subjects, the first essential ingredient of an effective letter to a legislator is a specific reference to the particular bill which interests you—H.B. 00 or S.B. 00.

The second important element is a brief description of the bill's provisions, and an explanation of the effect which these provisions will have on you.

The third element of an effective letter is your advice to your legislator as to how, in your opinion, he should cast his vote.

The proper address style for both the letter and envelope is:

State Senator:

The Honorable John Doe The State Senate State House Columbus, Ohio 43215

State Representative:
The Honorable Robert Smith
House of Representatives
State House
Columbus, Ohio 43215

REMEMBER: Legislators receive correspondence from their constituents at both their homes and their offices. It usually is better to address them to Columbus when the legislature is in session.

Senate Chamber: (614) 466-4884 House Chamber: (614) 466-2312 Legislative Public Information Office: Columbus Phone (614) 466-8842 All other areas (800) 282-0253

vote. If it has been defeated by a constitutional majority, however, it cannot be considered again except by suspension of the rules.

A BILL WHICH REACHES the second house is subject to all the opportunities to succeed or fail which exist in the house of introduction. In addition, bills sometimes reach the second house so late in the session there is not time for that house to act before the session ends.

bill which survives the hazards of both houses but is amended in the second chamber in a manner unacceptable to the house of origin must go to a conference committee consisting of 3 members appointed from each house. The committee members attempt to reach an agreement that will be acceptable to legislators in both chambers. Bills sometimes die because no such agreement can be reached.

Committees Of Special Importance To Physicians

HOUSE COMMITTEES

Education

Roberto (D)—Chairman; Boggs (D)—Vice Chairman.

(D)—Bell, Brown, Christman, Feighan, Hartley, R. James, J. Johnson, Locker, Panehal, Wojtanowski (R)—Scott, Betts, Fix, Kieffer, Maier, Murdock, Rose, Turner, Wingard

Human Resources

Hale (D)—Chairman; Hartley (D)—Vice Chairman.

(D)—Deering, Locker, Orlett, Rankin, Rocco

(R)—R. Hughes, Fox, Karmol, Maier

Judiciary

Lehman (D)—Chairman; Nader (D)—Vice Chairman.

(D)—Brooks, Brown, Eckart, Feighan, Healy, Leonard Orlett, Roberto, Rocco, Smart, Stinziano

(R)—Batchelder, Betts, Brandenburg, Finan, Maier, O'Neill, Oxley, Saxbe

SENATE COMMITTEES

Education and Welfare

Jackson (D)—Chairman; Pease (D)—Vice Chairman.

(D)—Bowen, Celebrezze, Stano, Zimmers

(R)—Collins, Gaeth, Van Meter

Health and Retirement

Calabrese (D)—Chairman; Secrest (D)—Vice Chairman.

(D)—Freeman, Pease, Stano, Zimmers

(R)—Collins, Dennis, Gray



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Warnings: Patients with severe cardiac disease should be given this medication with caution. Fever and possibly heat stroke may occur due to anhidrosis.

Overdosage may cause a curare-like action, with loss of voluntary muscle control. For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted. Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthīne.

Precautions: Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

Dosage and Administration: The recommended daily dosage for adult oral therapy is one 15-mg, tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

How Supplied: Pro-Banthine is supplied as tablets of 15 and 7.5 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg.



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An Inside Look At The State **Medical Board**



OSMA members often have questions concerning the complex policies and practices of the Ohio State Medical Board. In order to gain insight into how the Board works, David Rader, OSMA's State Legislative Director, interviewed William J. Lee, Administrator of the Board. The interview will be published in two parts. In this issue, the procedures for licensing, endorsement, the FLEX Exam, and the Fifth Pathway are explained. Mr. Lee also discusses how these procedures are enforced. Next month's conclusion will cover the topics of acupuncture, physician's assistants, the disabled physician, and the Board's budget.

OSMJ: In preparing for this interview, we solicited questions from the county medical societies. Many of our questions will result from their responses. Bill, perhaps you would like to start by giving us some background about your education, work experience, and how you came to assume this position.

LEE: I went to the University of Akron and later got my law degree at Ohio State University in 1948. Since that time, I have practiced law privately; served in the Ohio Department of Liquor Control; served as acting municipal judge (upon request of the court); taught as a part-time instructor at Kent State University; and served as Assistant City Attorney for the City of Ft. Lauderdale, Florida. I've been with the State of Ohio Medical Board for eight years. This includes four years in the attorney general's office, where I was assistant attorney general and represented all of the professional boards. I became Administrator of the Ohio State Medical board in December 1970.

OSMJ: Is your position a civil service position, or do you serve at the pleasure of The Governor or the State Medical Board?

LEE: I am a certified civil service employee, appointed by the State Medical Board and directly responsible to the Board.

OSMJ: You're not responsible to The Governor?

LEE: No, Sir.

OSMJ: Bill, do you define staff duties within the State Medical Board, and if so, can you outline some of those duties for us?

LEE: First, I am the administrator of an eightmember board. I work with advisory committees, including the Chiropractic Advisory Committee, Cosmetic Therapy, Massage, Podiatry, Physical Therapy, and The Ohio Osteopathic Association and Ohio State Medical Association. In addition to these committees, an assistant attorney general assists me with legal matters.

I have two administrative assistants. Captain Edward Valentine, a former member of the State Highway Patrol, is in charge of enforcement. He supervises five investigators. Michael Detty is the other administrative assistant.

Our office is then divided into several sections, each with specific duties. There is a separate section for each of these operations: fiscal; temporary and unlimited certificates; FLEX Examinations; preliminary education requirements and endorsements for American graduates; foreign medical graduates endorsement; and records.

OSMJ: Let's talk about a couple of those areas specifically. First of all, is the assistant attorney general assigned to you full-time, Bill?

LEE: Yes, we pay half of his salary. That arrangement was worked out with the attorney general.

OSMJ: Do you consider one full-time legal counsel sufficient for an operation of this size, Bill?

LEE: No, I don't. We do have several legal aides who assist us in legal matters, but under the law the attorney general is our only official counsel. Therefore, any person who represents us has to flow from the at-







torney general's office. It would be highly desirable to have at least one other full-time assistant attorney general.

OSMJ: Is there any prohibition against retaining legal counsel from private firms?

LEE: We have some counsel from lawyers in private practice, but they are technically with the attorney general's office and their power flows from the attorney general.

OSMJ: You license many health professionals other than physicians. Can you give us some idea of the different kinds and numbers of licenses?

LEE: I can give you a run-down on the kinds of licenses we issue. As of December 31, 1974, we licensed approximately 22,014 Doctors of Medicine, 1,750 Doctors of Osteopathy, 610 Doctors of Chiropractic, 465 Doctors of Mechanotherapy, 680 Doctors of Podiatric Medicine, 1,079 physical therapists, 340 cosmetic therapists, 1,498 masseurs, and 25 midwives.

OSMJ: Your responsibility here at the Medical Board, therefore, covers more than 28,000 people. Yet you have only five investigators to look into possible problems with those 28,000 licensees. Does that mean that you don't have very many problems or does that mean you need more investigators?

LÉE: We need more investigators. Fortunately, we do have the assistance of local law enforcement personnel: county prosecutors, municipal prosecutors, police, sheriffs' offices, etc. We also have the Federal Government and drug enforcement administration helping us.

OSMJ: The Ohio State Medical Association recently testified before the Senate Finance Committee requesting funding for additional investigators. How many more investigators does the Board need?

LEE: It would certainly be fine if we could bring in another 16 or 17 investigators. We could use them. However, it's not easy to find qualified people, to say nothing of training them.

OSMJ: Do you consider your salary schedules high enough to attract qualified investigators and other staff personnel?

LEE: I think the salary schedule should be raised, although I don't consider it a major problem at this point.

OSMJ: Bill, members of the press, General Assembly, the public, and many Ohio physicians complain that the Medical Board just "whitewashes" cases that are placed before it. They feel it does not aggressively prosecute physicians who should be removed from the practice of medicine. How many times recently has the state medical board taken away a physician's license?

LEE: I'll give you some figures for 1974. In that year, we had five drug enforcement administration certificates surrendered. In those situations, we felt the physicians and their patients would benefit most if the physicians turned in their controlled substances certificates. Next, we had nine formal hearings. One case was dismissed and one physician died. In the other seven cases, one defendant received a four-month suspension and another got a three-month suspension. One

physician was found ineligible to take the FLEX examination until 1980. A limited practitioner had his license revoked, and the remaining three cases ended in Consent

OSMJ: What's a Consent Order?

LEE: A Consent Order is when the attorney general, the hearing member, and the attorney for the defendant decide that a certain order may be consented to in order to alleviate the case.

OSMJ: In other words, the person says he's not guilty, but he agrees not to do it again?

LEE: In some instances, he or she may even indicate guilt. Getting back to our 1974 figures, I'd like to point out the criminal aspect of the Board's work. In many situations, we work with local prosecutors and the case may or may not result in arrest. We had a total of nine arrests last year.

OSMJ: Were those M.D.'s or different types of cases?

LEE: Usually, arrest situations don't involve people who are licensed. Here is a breakdown of the nine arrests in 1974. The cases involved: a masseur; an unlicensed practitioner; a limited practitioner delivering a baby; a person practicing midwifery without a license; an unlicensed physical therapist; an osteopathic doctor charged under the pharmacy laws; an alleged medical student; a limited practitioner practicing acupuncture; and a doctor who procured a narcotic drug by fraud and deceit.

This does not in any way present the entire picture of our enforcement effort. I think one of the best ways to get the entire picture would be to come over and watch Ed Valentine and me work on different complaints and enforcement matters for a couple of days. I'd like to invite anyone affiliated with the academies or OSMA to do so.

A large portion of our enforcement effort consists of calling people into the office. Either Dr. Ruppersberg, our president, or one of our board members and Capt. Valentine talk with the person. In 1974, we had 35 people called in because of alleged violations of the medical practice act or some problem involving the AMA code of ethics.

We also try to help doctors who are having drug, alcohol, or emotional problems. In doing so, we work closely with the psychiatrist or the OSMA Committee on Mental Health. We even have one case where the doctor has volunteered to submit to random blood tests every month or so. His attorney then reports the test results to us. It is amazing how well that case is working out.

OSMJ: Let's talk about how a physician gets a license and what types of licenses exist. Tell us, for instance, what the procedure is for a student who is getting out of medical school and wants to obtain a license in the state of Ohio.

LEE: As you know, Ohio has had the FLEX Examination since 1966.







OSMJ: What does that stand for?

LEE: That's the Federal Licensing Exam. This exam originated approximately 10 years ago and has been accepted by most states. It's a 3-day examination administered all over the U.S. on the same day twice a year.

OSMJ: A person graduating from medical school should apply to this office to take the FLEX Exam?

LEE: That's correct. When we receive a letter, the first thing we do is to obtain preliminary information and credentials. We must have evidence that the person is a graduate of an approved medical school before we can send out an application form. All applicants must also meet citizenship requirements. If he or she is a citizen or has a Declaration of Intention, there's no problem.

Now, if a person doesn't have either, then he or she has to have an approved petition for a permanent visa or an immigration card. These are preliminaries to getting a Declaration of Intention or becoming a citizen.

OSMJ: Are these requirements uniform all over the country?

LEE: No, each state has its own requirements in terms of citizenship.

OSMJ: We understand, Bill, that a physician can become licensed in Ohio without actually sitting for the FLEX Exam. Could you explain how?

LEE: One way a physician can do so is by endorsement. If you have a full license in another state and are a diplomate of a national board (either the FLEX Examination or the Osteopathic Board), you can become licensed providing you have taken a written examination in the state from which you are endorsing. The endorsement procedure is much less complicated for American graduates than for foreign medical graduates.

OSMJ: What's the difference between reciprocity and endorsement?

LEE: From a legal standpoint, reciprocity means "you endorse our people—we endorse yours." Ohio doesn't have any reciprocity agreements.

OSMJ: In other words, applicants have to show you adequate credentials before you will issue them a license without an examination?

LEE: Yes. There's a substantial amount of work involved in reviewing these credentials, particularly for foreign medical graduates. Any OSMA member or any member of the general public desiring additional information about this, may contact our office.

OSMJ: Bill, would you explain to us the procedure for the Fifth Pathway and tell us whether or not it has proven workable in this state? (Editor's Note: The Fifth Pathway is one of the five official AMA methods for a foreign medical graduate to become licensed.)

LEE: H.B. 1008 was passed last year by the legislature, allowing foreign medical graduates to get into the Fifth Pathway program. To do so, they have to take parts one and two of the national board, or parts one and two of the FLEX Exam, or the ECFMG. The foreign medical graduates then take a year of clinical clerkship training and a year of approved training (residency). After meeting those requirements, they are





entitled to be admitted to the state medical board FLEX Examination. The number of physicians in Ohio in Fifth Pathway programs has been somewhat limited, although the program is working.

OSMJ: What's the ECFMG, Bill?

LEE: The letters stand for the Educational Council for Foreign Medical Graduates. This examination shows if foreign medical graduates are qualified to enter the Fifth Pathway program.

OSMJ: It's a test that's given all over the world? Is that accurate?

LEE: I believe that it is.

OSMJ: Again, Bill, we assume that people can contact your offices for information concerning the ECFMG testing or endorsement of Fifth Pathway graduates.

LEE: They surely can. I might say that we're making a special effort to give efficient and excellent service.

OSMJ: Do you have a written policy statement regarding non-citizen licensing requirements?

LEE: It's not in pamphlet form, but we have a



very complete package for each particular situation. The Board's requirements with respect to licensure are described in great detail. I'd be more than happy to make these available for anyone desiring information.

OSMJ: While we are still talking about licensure, Bill, it has come to our attention that there have been some problems with getting renewed licenses mailed out before current licenses expire. Is this a problem? And if so, is there anything being done to correct this? Is a physician practicing in jeopardy if he does not have a current valid license because he has not received one from you?

LEE: Not if we haven't got the cards out in time. If for any reason cards are late going out, we take into consideration that particular situation. I think it's important to emphasize that doctors must keep us informed of changes of address so they can get their renewals back in time. However, if the renewals have been sent out in time and the person is practicing without his renewal license, we would have to close the place down. We are presently checking out some of these situ-

ations to make sure that people are not unlawfully operating. Renewing licenses is a big operation and problems do develop. For example, last time we did our roster, we had a paper shortage, a computer breakdown and a number of different problems.

OSMJ: How often, by law, is the roster supposed to be mailed to all licensees?

LEE: It's supposed to be mailed out every two years. Our next roster is now being proofread and is moving along really well.

OSMJ: Bill, let's talk for a minute about temporary and limited licenses. Can you explain how the state of

Ohio uses temporary and limited licenses?

LEE: The temporary license is set up under 4731.291 and allows an applicant with a proper medical degree to get into an approved internship and residency program. If he meets the qualifications as indicated by the statute, he is issued a temporary license to practice within the confines of the hospital only. I think the temporary certificate has caused a lot of confusion in this state. To some extent it can be a breeding grounds for unlawful practice of medicine by people that really aren't fully qualified.

OSMJ: So this permits an individual to practice medicine within the confines of an institution as part of the learning experience without taking a test. Is that

accurate?

LEE: Yes, that's correct.

OSMJ: But he may not practice independently under a temporary certificate?

LEE: That's right and it's important to point out that he must be under supervision of the hospital's medical staff.

OSMJ: What's a limited license, Bill?

LEE: Under 4731.292, a person who is not a citizen can apply for a preliminary registration, meaning he has passed the ECFMG and meets other requirements. He can practice in a state hospital, but it has to be under the supervision of a fully licensed practitioner. Then he can take the state medical board exam and get a limited certificate. After he has had two years of training, and becomes a citizen, he can get a full license.

OSMJ: However, you said earlier that he didn't

have to be a full citizen to get a license.

LEE: That's an excellent point. It's one of the anomalies in the medical practice act. Under this particular section of the statute, if you go into a state hospital, you do have to be a citizen to get a full license.

OSMJ: Are you suggesting that limited license requirements should be eliminated in the near future, Bill?

Is that the position of the Board?

LEE: In my own personal view and not that of the Board's the limited license tends to help unlicensed practitioners get into state hospitals where fully licensed physicians are desperately needed. Just the other day, I presented a memorandum to the Board asking for their advice and suggestions in this particular matter. I've also indicated in a memorandum to the OSMA that we will have some further concern in this particular area.

The interview will be concluded in next month's issue.

The post-T&A patient:

another type for Tylenol acetaminophen products



When the post-T & A patient requires an analgesic, a new problem arises. Hemorrhagic tendencies following the use of aspirin after tonsillectomies have been reported. In a patient who "...has recently undergone a surgical procedure or has another underlying hemostatic defect, aspirin ingestion may cause significant bleeding.... Aspirin is absolutely contraindicated in such situations. Acetaminophen... could replace aspirin in these instances." 3

The post-T & A patient is only one of several 'types for TYLENOL' antipyretic-analgesic products—that is, patients who should avoid aspirin. Considering *all* of them, wouldn't it provide added safety (as well as added convenience) to recommend TYLENOL products routinely for simple analgesia?

References: 1. Reuter. S.H., and Montgomery, W.W.: Arch. Otolaryng. 80:214-217 (Aug.) 1964. 2. Osol, A., et al., ed.: The United States Dispensatory and Physicians' Pharmacology, ed. 26, Philadelphia, J.B. Lippincott Co., 1967, p. 171. 3. Schwartz, A.D., and Pearson, H.A.: J. Pediat. 78:558-560 (March) 1971.

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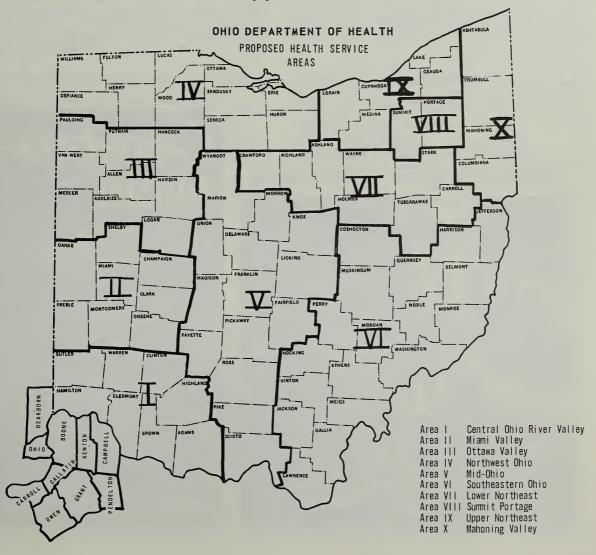
Director of Health

Health Service Areas

The Ohio Department of Health conducted four public reviews during April on proposed health service areas, as required by the National Health Planning and Resources Development Act of 1974. We had an excellent turnout for the reviews which were held in Lima, Cincinnati, Marietta and Akron.

After reviewing the information and testimony submitted, we have recommended to the U.S. Department of Health, Education and Welfare that Ohio be Divided into 10 health service areas. However, we made three changes in the areas originally proposed: Ashtabula County was changed from Area IX to Area X; Wyandot County from Area III to Area V; and Logan County from Area II to Area III.

Area III has slightly less than the minimum population required by federal law, so we have requested that that requirement be waived. None of the proposed areas exceeds the maximum allowable population of 3 million.



Amanda Township

A grant of \$18,355.00 has been awarded to Amanda Township (Fairfield County) for the purchase of an ambulance and communications equipment. The vehicle will be manned by the Amanda Township Volunteer Fire Department to provide emergency medical services to Clearcreek, Hocking and Madison townships and also to the village of Amanda. The ambulance will be radio dispatched by the Fairfield County Sheriff. The Emergency Medical Services Program is administered by the Ohio Department of Health and funded by the U.S. Department of Transportation.

School Immunizations

The Cincinnati City Health Department has been doing a good job of enforcing the state school entrance law. Children who had not begun the immunization series were suspended from school until their parents signed a consent form. Immunizations were administered to those children whose parents had given consent.

The Jefferson County Health Department has also been busy. Approximately 9,000 children in two school districts have been immunized.

Investigations

Members of the Ohio Department of Health's radiological health unit are continuing to investigate an incident at a large industrial research facility which resulted in severe radiation injury to an employee. Two fingers of the employee's right hand had been exposed to an intense X-ray beam while the employee attempted to repair a component of a spectrographic X-ray unit without turning off the X-ray tube.

The Ohio Departments of Health and Agriculture have been informed by the federal Food and Drug Administration that its laboratory tests of a sample of canned mushrooms have yielded no evidence of botulism contamination. FDA reports that exhaustive testing indicates the bulging of several cans was caused by defective can construction which allowed air to leak in, with subsequent putrefecation. Fisher Foods of Cleveland has been commended for voluntarily removing canned mushrooms of the same batch number from its shelves while the samples were being tested.

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An omnibus malpractice bill (H.B. 682), which the Ohio State Medical Association actively supports, is ready for House Debate on Tuesday, June 17.

OSMA is actively working for legislative action on H.B. 682 by July when the Ohio General Assembly is expected to recess. The professional liability crisis must be solved by next month since a great number of physicians will face insurance policy renewals in July.

Many other state medical societies are also involved in professional liability legislation. Below you will find highlights of what was happening in some of these states at the time The Journal was printed.

CALIFORNIA—While legislators pondered the professional liability situation, surgeons and anesthetists in Northern California limited acceptance of patients to "life and death" conditions. A number of pertinent bills have been introduced.

IDAHO-Recently passed laws: provide for a joint underwriting association established by the state insurance commissioner; limit damages to \$150,000 for one person filing a claim for one incident and \$300,000 for multiple claimants; restrict informed consent; limit contingency fees to 40 percent of the settlement; and allow physicians and hospitals to establish their own insurance company.

ILLINOIS—Three bills have been approved by a House Subcommittee. The first bill prohibits suits for punitive damages. The second limits the statute of limitations to one year from the time of discovery and four years from the injury's occurrence. The final bill allows the plaintiff's disability and social security benefits to be introduced as evidence in trial. Action has been deferred on a bill limiting damages to \$500,000 and establishing a review panel in each judicial circuit.

INDIANA—Governor Otis Bowen signed a bill establishing screening panels to review malpractice claims; setting a \$100,000 ceiling on damages against physicians; and limiting the statute of limitations to two years from the date of the injury's occurrence.

IOWA—The Legislature is reviewing six proposals sponsored by the state medical society.

MARYLAND—A law has been passed authorizing the country's first non-profit mutual liability insurance company run by physicians.

MICHIGAN—The Supreme Court is considering a sliding scale for contingency fees in professional liability cases.

NEW YORK—The state medical association opposed both the government's insurance proposal and the joint underwriting association proposed by the insurance industry. As a result, the medical society is collecting capital funds to form a captive mutual insurance company if necessary.

NORTH DAKOTA-Laws reduce the statute of limitations to six years and protect the records of hospital review committees. The state medical association is also authorized to establish a mutual insurance company if necessary.

WISCONSIN—The first joint underwriting association bill in the country was passed and signed. It is for physicians who are unable to find other insurance coverage and is on a claims-made basis only.



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the federal scene

Comprehensive Health Care Insurance Act of 1975 (H.R. 6222)

The AMA-sponsored "Comprehensive Health Care Insurance Act" or H.R. 6222 has been introduced before Congress by Representatives Tim Lee Carter, M.D. (R-Kty.), John Duncan (R-Tenn.), Richard Fulton (D-Tenn.), and John Murphy (D-N.Y.). A similar bill is slated for introduction in the Senate. H.R. 6222 replaces the 1974 Medicraft Plan, also developed by the AMA, which had 182 Congressmen as sponsors. Following is a summary of the draft proposal for H.R. 6222.

Full Health Care For All

The basic concept of this proposal is full health care for all persons through private health insurance. For many who are now employed and have some insurance protection, it will mean a substantial increase in allowable benefits that will assure that their health care needs will be met. Equally comprehensive benefits will be available to the poor and the indigent, through federal participation in the cost of insurance. A special program of supplemental insurance will provide like protection for the Medicare population.

Mandated Employer Coverage

Most persons will receive their health care protection under employer insurance programs fully financed by premium paid by employers and their employees. Employers will be required to offer the coverage, and participation will be optional for the employee. 65% of the premium will be payable by the employer (and he could pay more) for the benefit of the employee and his family; the employee will pay the balance.

Individuals regularly working at least 20 hours per week, as well as full-time employees, will be entitled to this coverage.

Self-Employed, Non-Employed, and the Elderly

Needs of the poor and the medically indigent will be met through a system of insurance premium subsidies providing either credits against income tax, or "certificates of entitlement" acceptable by carriers toward payment of premium. Such subsidies will be scaled according to income, and will pay all of the premium for some and a part of the premium for others. The manner in which such subsidy is provided is described below.

A non-employed person or a self-employed person would buy health care insurance which is "qualified," that is, meets federally established standards and conditions of coverage affording him and his family full

care—diagnostic, therapeutic, and preventive, in and out of the hospital. He could choose to pay the premium, in which case, when completing his income tax return at year-end, he would simply reduce the amount of his income tax by the amount of credit to which he is entitled. On the other hand, he might choose, instead, to make application for a certificate of entitlement. His insurance company would help him, if he wished, and even put the insurance in force pending receipt of the certificate (with the government guaranteeing payment of the premium during the interval between application and receipt of the certificate).

The amount of the federal contribution will be based on individual or family income, measured by income tax liability for the year preceding the year for which the purchase is made.

Continuity of Insurance for the Unemployed

Persons between jobs will be covered under a special program. All employer-sponsored insurance will provide coverage of employees and their families for 30 days following termination of employment. In addition, however, an individual will, during the period for which he is entitled to unemployment compensation, be eligible for continuation of the insurance he had at the time of his termination of employment, and such continuing insurance will be fully paid for by the federal government. To further assure continuity of coverage, if this eligibility should expire before he is relocated in new employment, he will be able to obtain coverage as an non-employed person, at no cost to him, for the remainder of the year.

Benefits

Health benefits under the program are comprehensive and afford the basic needs as well as the catastrophic expenses that a family might encounter. Any person covered under the program will be entitled to all the hospital inpatient care he might need, as many as 100 days of inpatient care in a skilled nursing facility, and all home health services. Each member of the family will also be entitled to full physician services, providing all surgical needs as well as general care, and a full range of preventive services, including physical examinations, immunizations and innoculations, and outpatient psychiatric care. Children under 7 will be fully covered for dental care, and this age limit will be raised each year so as ultimately to include all persons under 18. Adults will be covered for emergency dental care.

But the plan will not pay for items normally excluded, such as comfort items or cosmetic surgery.

Coinsurance Requirements

To keep costs down, and as a curb against overutilization, some coinsurance will apply. Benefits will be subject to coinsurance at a rate of 20%, but the total coinsurance which a family will have to pay in any year will be limited according to its income. The poor will pay no coinsurance, others will pay a maximum in any year of 10% of income reduced by a "coinsurance deduction" that will assure that the obligation for coinsurance will increase only gradually as income rises. In effect, a family of four with a total income of \$4,200. who have no income tax liability, will be exempt from coinsurance. At \$4,300 of income, the coinsurance limit would be 10% of the additional \$100 of income, or \$10; at \$10,000 the limit would be \$580. In no case would the annual coinsurance limit be more than \$1,500 for an individual or \$2,000 for a family. The limitation on coinsurance triggers the catastrophic expense protection, for health services are free of coinsurance when the limit is reached

Insurance Availability

Insurance will be available to all persons, regardless of prior medical history and on a guaranteed renewable basis. All carriers will offer the insurance, and will participate in an assigned-risk pool, if the State believes such pool is necessary to assure the availability of the coverage. In addition, premium for individuals or small groups within a state will be not more than 125% of the cost of insurance for members of large employee groups (over 100 persons) in a state.

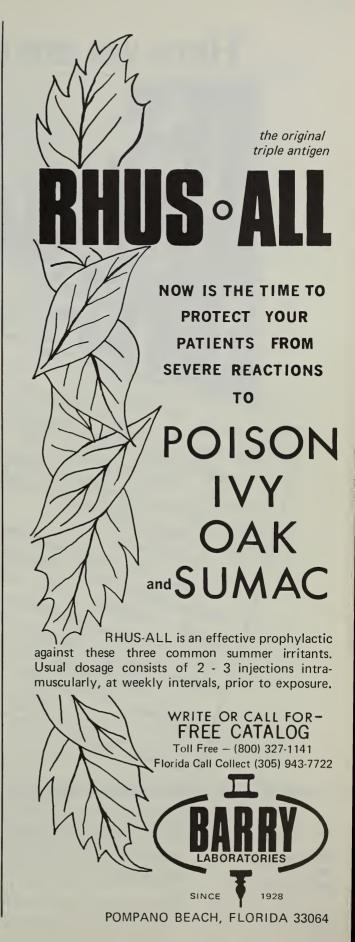
Although participation in the insurance program is voluntary, individuals are expected to enter the program as they become eligible.

Administration

State governments will regulate insurance within the state, subject to federal guidelines established under the program by a 15-member Health Insurance Advisory Board. The Secretary of HEW and the Commissioner of Internal Revenue will be members of this Board, and the additional members will include 6 practicing doctors of medicine, a doctor of osteopathy, a doctor of dentistry, and members of the general public. The new Board will also consult with carriers, providers and consumers in planning and developing programs for quality medical care, and will make annual progress reports to the President and to the Congress.

Limitation on Civil Liability

A separate measure in the bill is directed against the duplication of claims for medical costs in legal actions for damages. Under this provision, no liability will be recognized in an action against a medical provider with respect to costs for services which are payable under the national health care program or any Social Security program.



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proceedings of the council

A regular meeting of the Council of the Ohio State Medical Association was held Saturday and Sunday, April 26 and 27, 1975, at the Columbus Headquarters' Office, 600 S. High Street, Columbus, Ohio.

Those present Saturday were: All members of the Council, with the exception of Drs. Clarke, Wells, Hogg and Tye; Mr. James E. Pohlman, Esq., Columbus, OSMA Legal Counsel; Dr. Richard L. Meiling, Columbus, member of the Ohio Delegation to the AMA; Dr. William R. Schultz, Wooster, Chairman of the Committee on Membership and Planning; Dr. Donald J. Vincent, Columbus, Chairman of the Committee on Medicine and Religion; Dean Van Bogard Dunn, Delaware, Methodist Theological School, and Messrs. Page, Edgar, Gillen, Campbell, Clinger, Rader, Houser, Holcomb, Mulgrew, Mrs. Wisse, Mrs. Dodson, Mr. Freeman, and Ms. Doll, of the OSMA Staff.

Those present Sunday were: All members of the Council, with the exception of Drs. Clarke, Wells, Hogg and Tye; Mr. Pohlman; Dr. Thomas D. Stevenson, Columbus; Dr. Anthony Ruppersberg, Jr., Columbus, Chairman of the Committee on Maternal Health, and all members of the OSMA Staff, with the exception of Mrs. Tanner and Ms. Doll.

The meeting was called to order by President Henry.

The minutes of the March 8-9, 1975 meeting of the Council were approved.

Membership

Membership statistics were presented by Mrs. Wisse for the information of the Council.

Fiscal Matters

It was announced that insurance had been obtained to cover the fiduciary obligations of the Pension Committee.

American Medical Association

In the absence of Dr. Robechek, Dr. Meiling reported for Ohio's AMA Delegation. He discussed the hearing of the AMA Council on Constitution and Bylaws with regard to the delineation of the role of the AMA Judicial Council.

Dr. Henry announced that Dr. Meredith has resigned his position as an AMA Delegate, creating a vacancy to be filled at the Annual Meeting.

Minor amendments were adopted with regard to a resolution on the American Medical Political Action Committee to be submitted by the Ohio Delegation at the June meeting of the American Medical Association.

OSMA Annual Meeting

The President distributed to each Councilor the assignments of resolutions to each of the three Reference Committees for the OSMA Annual Meeting.

Dr. Henry Congratulated

On a motion by Dr. Rinderknecht, the Council adopted a resolution of congratulations and thanks to Dr. James L. Henry, for his leadership as President and Chairman of the Council during the past 12-months.

A resolution of thanks to Drs. George N. Bates and James C. McLarnan for their long years of service on the Council was adopted. The terms of both expire at the 1975 Annual Meeting.

MAI/OFMC

The Council was recessed and a joint meeting of the members of Medical Advances Institute and the Ohio Foundation for Medical Care was convened and held.

The Council was reconvened following the adjournment of the meeting.

Ohio Medical Indemnity, Inc.

Drs. Thomas and Smithson presented the Liaison Committee report with regard to Ohio Medical Indemnity, Inc.

It was announced that at the Annual Meeting of OMI, Dr. Dwight L. Becker was elected chairman of the Board of Directors; Dr. William M. Wells, vice-chairman; Dr. James G. Roberts, secretary; and Mr. Frank D. Robinson, treasurer.

Ohio Foundation for Medical Care

Mr. Gillen presented, for the information of the Council, the minutes of the Board meetings of the Ohio Foundation for Medical Care, held March 12 and April 13, 1975. He also discussed the seminar conducted by OFMC on April 13.

Committee Reports Committee on Medicine and Religion

The minutes of the Committee on Medicine and Religion meeting of February 19, were presented by Dr. Donald J. Vincent, chairman, who was accompanied by Dean Van Bogard Dunn, of the Methodist Theological School, Delaware. Dean Dunn is the chairman of the Commission on the Role of Professions in Society.

The Committee on Medicine and Religion recommended the support of the activities of the Commission.

The minutes were accepted for information, with thanks to Dean Dunn and Dr. Vincent for their presentation.

Subcommittee on Children's Cancer Data Collection, OCCC, Inc.

The minutes of the Subcommittee on Children's Cancer Data Collection (OCCC, Inc.) meeting of March 17, were presented by Mr. Clinger, and were accepted for information.

continued

proceedings of the council

Commission on Medical Education

The minutes of the Commission on Medical Education meeting of March 19, were presented by Mr. Edgar, and were accepted.

Committee on Government Medical Care Programs

The minutes of the Committee on Government Medical Care Programs meeting of April 2, were presented by Mr. Houser. Recommendations of the Committee accepted by the Council included:

- 1. Opposition to a proposed new system regarding the "buy-in" agreement with Nationwide Insurance with regard to paying the deductible and coinsurance on Part B Medicare coverage.
- 2. Endorsement of efforts to eliminate a double billing procedure and the mandatory acceptance of assignment in the establishment of a proposed mechanism for reimbursement in regard to Medicare-Medicaid crossover.
- 3. Opposition to changes in Welfare invoices which would make them more complex, specifically, in the item of third party payment—other payment sources.
- 4. Encouragement of physicians and medical societies throughout Ohio to get involved in activities relating to the National Health Resources and Planning Act of 1974.

Committee on Membership and Planning

The minutes of the Committee on Membership and Planning meeting of April 12, were presented by Dr. Schultz.

The Council approved the Committee's proposal for an opinion survey of the members of the Ohio State Medical Association, following up a previous survey held in 1970. The Councilors were requested to submit to Mr. Page any suggestions regarding the questionnaire within the week following the Council Meeting.

Other proposals of the Committee approved by the Council were:

- 1. That each Committee develop 5-year goals and objectives at the first regularly scheduled meeting of the Committee, following the Annual Meeting.
- 2. That disbursements of specific funds for projects of each committee be considered for approval by the chairman of the Auditing and Appropriations Committee or the Executive Director.
- 3. That all committee reports and publications use disease entity as their base rather than case studies.
- 4. That the Thomas E. Rardin Scholarships be continued.
- 5. That a 5-year plan for the Association be submitted to the Council by the Committee on Membership and Planning and the Auditing and Appropriations Committee.

Committee on Emergency and Disaster Medical Care

The minutes of the Committee on Emergency and Disaster Medical Care meeting, held April 12, were presented by Mr. Houser, and were accepted.

Committee on Laboratory Medicine

The minutes of the Committee on Laboratory Medicine meeting, held April 16, were presented by Mr. Rader, and were accepted.

Committee on Insurance

The minutes of the Committee on Insurance meeting of April 17, were presented by Mr. Campbell.

The Committee's recommendations on the Informed Consent Provision of H.B. 682 were discussed. The informed consent form was referred to the Legislative Department for redrafting and subsequent consideration by the Task Force for Legislative Action on H.B. 682.

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A recommendation of the Committee, with regard to continuing medical education as a requirement for relicensure, as contained in H.B. 682, was accepted for information.

A proposal to Council that OSMA investigate establishing its own company to provide professional liability insurance was accepted for information.

With regard to a proposal of the Committee, the Secretary of the Committee on Insurance was instructed to write a letter to Ohio Medical Indemnity, Inc., and Medical Mutual of Cleveland, asking their attitudes toward establishing professional liability insurance coverage programs for physicians.

The Council approved the Committee's recommendation that OSMA members presently insured under the Group Ordinary Plan of OSMA be offered the opportunity to transfer their coverage to an equal amount of group term insurance under the OSMA Group Term Plan.

The Council approved the Committee's recommendation that the OSMA Corporate Employers Group Term Plan be supplemented with the new group ordinary feature from Union Central Life Insurance Company called "Permanent Value."

The minutes, as a whole, were accepted, as amended.

Committee on Mental Health

The minutes of the Committee on Mental Health meeting, held April 20, were presented by Mr. Clinger.

The Council accepted the Committee's recommendation that legislation calling for an increase in salary ranges of physicians in the Department of Mental Health and Mental Retardation be supported.

The Council did not act on a proposal that the Department of Mental Health and Mental Retardation be assisted in seeking a temporary waiver of the ruling that U.S. citizens are ineligible for temporary licensure between the time of taking medical licensure examination and the publication of the results.

The Council accepted for information the suggestion that the OSMA encourage liaison between departments of psychiatry of the state's medical schools and the Department of Mental Health and Mental Retardation for the purpose of promoting residencies in psychiatry.

Three recommendations with regard to the Physician Effectiveness Committee, scheduled for implementation July 1, 1975, were accepted.

The minutes were accepted, as amended.

Ad Hoc Committee on Complaint Procedures

Dr. Schultz, chairman, presented a summary of the study of OSMA complaint procedures and asked the Council to become familiar with it and to offer suggestions.

Committee on Maternal Health

Anthony Ruppersberg, Jr., chairman, Committee on Maternal Health, presented the 1972 Annual Report of the Committee. The report was approved for publication in *The Ohio State Medical Journal*. Dr. Ruppersberg requested a study by the Legislative Department of possible legislation to protect records of studies such as that conducted by the Committee on Maternal Health.

Councilor Reports

The Councilors reported on activities in their respective districts.

Federal Legislation

Mr. Edgar reported on various legislative developments in Congress.

State Legislation

Mr. Rader presented a report on state legislative proposals for Council action as follows:

H.B. 466, licenses a non-physical therapist as a physical therapist—active opposition.

H.B. 682, malpractice bill—active support.

S.B. 159, removes fluoride from drinking water—opposition.

S.B. 183, requires state institutions to purchase drugs by generic name—under study.

S.B. 201, places a podiatrist on the State Medical Board—no action.

S.B. 277, allows Controlling Board to vary professional licensing fees—under study.

The Council discussed H.B. 229, which would establish an Ohio school of osteopathic medicine in Athens, Ohio. The Council adopted the following statement:

"The solution to the physician distribution problem, as we see it best, is the Family Practice residency training program, as established by the Ohio General Assembly under the provisions of H.B. 474 of the 110th General Assembly. First priority is, therefore, this program to retain Ohio medical school graduates in the State of Ohio. In addition, two medical schools established by the 110th Ohio General Assembly, and the four existing medical schools, need adequate funds to continue their operation. The additional school provided by H.B. 229 would, therefore, be contraindicated at this time."

Amendments to the Constitution and Bylaws of County Medical Societies

The Council approved amendments to the Constitution and Bylaws of the Geauga County Medical Society, the Fairfield County Medical Society and the Academy of Medicine of Lima and Allen County. The amendments to the Constitution and Bylaws of the Greene County Medical Society were approved, subject to correction of minor clerical errors.

(continued)

proceedings of the council

Legal Counsel Report

Mr. Pohlman presented the report of the Legal Counsel.

The Council was presented a letter, dated April 25, 1975, from Mr. Pohlman to Mr. Gillen, with regard to a communication dated March 14, 1975, from the Academy of Medicine of Toledo and Lucas County, and a communication dated March 15, 1975, from the Geauga County Medical Society, discussing the subject of the appointment of one attorney for an individual county medical society to defend all professional liability suits in the area.

Field Service Report

Mr. Holcomb presented the report of the Field Service Department, including a meeting of the County Medical Society Executives, April 14, 1975, and visitations to 22 counties since the last meeting of the Council.

Professional Liability

On a motion by Dr. Pichette, seconded by Dr. Morgan, the Council voted to create a Task Force for Legislative Action on H.B. 682 (Drs. Henry, Lieber, Clarke and Bates), and empowered the Task Force to make decisions on an emergency basis between meetings of the Council.

The Council then considered a resolution from the Ohio State Bar Association, concerning professional liability insurance data collection.

The following statement was adopted by the Council as its position on the matter of professional liability insurance data collection:

"The Ohio State Medical Association supports measures for the collection and retrieval of all data necessary to solve professional liability underwriting problems on both a long range and a short range basis. These measures should be accomplished in addition to, but not in lieu of, the prompt passage of H.B. 682."

Statement on Professional Liability

The Council then **approved** the following communication from President Henry to the county medical societies:

"The professional liability insurance crisis must be solved by July, when the Ohio General Assembly is expected to recess.

"July is also the month when a deluge of professional liability policy renewals is due, and when interns and residents then completing their training will require malpractice coverage before they can begin the practice of medicine.

"A unified, coordinated approach is absolutely necessary if legislation is to be passed by July. Avoid running fights among those affected by the crisis and the bill. Negative, unilateral actions 'turn off' legislators, the news media, and the public.

"Legislative committees have three options when confronted with violent disagreements among parties interested in bills before them. They can kill the bill. They can sidetrack a bill into subcommittee and order the parties to resolve their differences there. Or, they can tell the dissident parties, 'Go back and develop a compromise.'

"Parties deeply involved in the professional liability crisis met January 30, 1975, in the Ohio Department of Insurance, and a consortium was formed. State Insurance Director Harry Jump was selected to lead the consortium in developing a bill to combat the malpractice insurance crisis.

"The Ohio State Medical Association, represented at this first meeting by its officers, staff and legal counsel, is a part of the consortium. A number of county medical society leaders present at that meeting participated in the consortium-legislative action agreement.

"The result, after ardous and long negotiations, is House Bill 682. Support of the entire package was not unanimous. Each group had to 'give a little,' thus avoiding delay of the legislation. We must be practical.

"Unilateral attempts to blame one or more parties for the malpractice crisis can seriously damage our efforts. Such attacks create antagonism and divert attention from the central issue, namely, solution of the problem. "Calling names and attempting to place blame destroys in the eyes of the legislators, and the general public, the credibility of those involved in such negative actions. Positive, not negative, support is essential.

"Your OSMA Council implores all county medical society leaders and members to act in unity with OSMA so that this legislation may become law before the General Assembly takes a July recess.

"Officers, Councilors and staff of the Association are available to sit down with county medical societies to assist them, to develop positive programs, and to inform them of the latest developments in Columbus.

"Emotionally charged actions, attempting to cast blame on others and to divert attention from our main goal can only hurt our efforts—and thus hurt medicine. Such running battles that may develop locally spill over into the Ohio General Assembly.

"Please help your profession to obtain the objectives so necessary for Ohio physicians and for the public. I urge you to:

- "1. Speak only to the issues, with tact and consideration.
 - "2. Be accurate, positive and not negative.
 - "3. Don't 'throw mud.'
- "4. Remember: OSMA is here to serve you. All you need do is ask.

Thank you,

James L. Henry, M.D."

Oncology

Dr. Thomas D. Stevenson, of Columbus, appeared before the Council to discuss the possibilities of forming a multi-disciplinary section on oncology. It was the opinion of the Council that the Association should, in response to Dr. Stevenson's request, expand the charge to the OSMA Committee on Cancer as a beginning in the evolution of a possible section devoted to oncology and representation of a number of medical disciplines.

Critical Health Manpower Shortage Areas

Mr. Page presented the following memorandum with regard to critical health manpower shortage areas:

"A new list of Critical Health Manpower Shortage Areas designated in the Federal Register 2/25/75. These areas are eligible to make application as potential National Health Service Corps (NHSC) sites. The Ohio list is as follows: Brown, Clermont, Jackson-the Oak Hill medical service area, Mahoning-Smith Township, Medina-the Medina medical service area, Pike, Putnam, Vinton, Warren."

Physical Education

The Council voted to support the improvement of the standards of elementary and secondary physical education in Ohio.

Immunization

The Council voted to support efforts to enforce immunization law requirements—on the basis of action taken by Arnold M. Leff, M.D., health commissioner in Cincinnati.

Yellow Pages

Mr. Page announced a new policy of the American Telephone and Telegraph, Inc., beginning October, 1975, in the Columbus area, to provide for a listing grouped by specialty, in addition to the alphabetical listing "Physicians and Surgeons—M.D." in the yellow pages.

White page listings and the alphabetical listing under "Physicians and Surgeons—M.D." in the yellow pages are paid for as a part of the physician's business telephone bill. The category listing by specialty will cost "\$2.00 a month in the larger cities and possibly less in the small cities and towns." This system is already in use in the Louisville, Atlanta and Milwaukee areas. The Council expressed "no obligation" to this proposal. Adjourned.

ATTEST: Hart F. Page

Executive Director



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NEW/ MEMBERS

Following are names of new members of the Ohio State Medical Association certified to the headquarters office during April 1975. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

Ashland (Ashland) Joohn S. Lee

Ashtabula (Ashtabula) In Won Kim

Auglaize

Thomas Dozier
St. Mary's
Richard P. Harbord
New Knoxville

Clermont

Natvarlal L. Patel Williamsburg Stanley C. Wang Milford

Columbiana (Salem) S. D. Patel

Crawford (Bucyrus) Keith D. Blair Cuyahoga (Cleveland)
George J. David
John Fernbach
Irene M. Hazelton
Steven M. Klein

Donald C. Mann

Franklin (Columbus)
Albert J. Lantinen, Jr.
Kenneth B. Weise

Geauga (Chardon) Vaclav I. Pokorny

Hamilton (Cincinnati) Jens G. Rosenkrantz

Huron (Bellevue)
Elbert D. Lawrence

Lake (Cleveland) Young Jai Lee

Lucas (Toledo) Bruce D. Janiak Ramon A. Milan-Ponce Suresh Ramnath A. Thambuswamy

Mahoning (Youngstown)
Milton H. Hamblin
Ung-Gill Jeong
Frederick W. Kunkel
Herbert A. Parris

Medina (Medina) Gunadi Sutandar

Montgomery (Dayton) Ahmad Abouhossein Dionisio A. Fernandes Harold J. Gauthier Maria Lim-Kong Prabhakar Rumalla

Ottawa (Elmore) Bhaskara R. Narra

Portage (Windham) Fu-Shan Lin

Richland (Mansfield) David D. Kukura

Sandusky (Fremont) Alexander Mathew

Scioto (Portsmouth) Harold L. Leitel Laura C. Pagel Seneca (Fostoria) Ramnath K. Pai

Stark (Alliance)
Donald A. Schlernitzauer

Summit (Akron except where noted) Robert M. Benson Emilio Co Chu Cuyahoga Falls Sheldon A. Friedman Hudson Satkari Iash Sinukuan C. Mariano Iose L. Martinez Antonio B. Montinola Cuyahoga Falls Bashar A. Mubashir Cuyahoga Falls Sergio Orozco Barberton Jitinder S. Rangar Russell B. Rothrock Nadhir D. Saddawi

Trumbull (Warren except where noted) Mostafa Rafii Yogesh O. Sheth Niles Bellaflor G. Villanueva Hsio-Hsion Wang



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Auxiliary

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Stark County leads the auxiliary parade. It was Ohio's first organized auxiliary. Believe it or not, the year of its founding was 1928, twelve years before the state organization came into being. At a recent festive luncheon in honor of its anniversary, the group paid tribute to the six living charter members: Mrs. L. E. Leavenworth, Mrs. H. L. Weaver, Mrs. H. J. Schwensen, Mrs. Ralph Ramsayer, Mrs. R. E. Hall and Mrs. J. F. Toot. Mrs. Sylvester Centrone, 1974-75 Stark president, together with Mrs. William Myers, state membership chairman, carried out beautiful and meaningful presentations of tribute to these early auxilians. Another festive occasion followed on the heels of the birthday celebration—a dinner dance for the group's Student Loan Fund. This fund which made its first loan in 1937 has helped 104 students to date and involves more than \$56,000. At the present time, twenty-nine students are in various schools in Ohio in the fields of nursing, bio-medical engineering and medical technology. This project is no small job for its dedicated chairman, Mrs. Angelo Demis (there are some \$33,000 out in loans!)

Moving Around

It was "April in Paris" for the Cuyahoga auxiliary's 1975 version of its annual Lilac Time. Given each year for the benefit of the Philanthropy Fund, it is a gala occasion indeed (I've been there and I know!). "Director" of this year's production was Mrs. Roscoe J. Kennedy. She's the gal with the touch of magic and unbelievable creativity. There were "gendarmes" to greet the guests and French maids in abundance and the Left Bank Flea Market with its colorful stalls. There was the Champs Elysees with its always successful "silent auction". There were three sidewalk cafes for refreshments and finally the Cafe Rue de la Paix for a French cuisine luncheon. Possibly the piece-de-resistance were the dancing girls and their Folies Bergere number, followed by a breath-taking fashion show. This 1975 April in Paris involved some 35 chairmen and co-chairmen plus a score of models from the Cuyahoga auxiliary. Woman in the News: Mrs. Christopher Colombi, a past state president from Cuyahoga County and an outstanding auxiliary member, was one of three Cleveland women honored recently with the Margaret A. Ireland Award for civic achievement and community service. I wish I had the space to detail Vi Colombi's accomplishments in her community. They could fill a column by themselves . . .

Another outstanding Nursing Scholarship Fund is that of Franklin County and it was the focal point at the group's recent smorgasbord luncheon at the Covenant Presbyterian Church. One of sculptor Ann Entis' cherubic terra cotta children was a special prize that day to a lucky donor to the Fund. The Franklin auxiliary currently has twelve nurses on scholarships. According to Mrs. Don Lewis, president, scholarships are given to women only after they have completed their first quarter of nurses' training. The luncheon was the occasion of a "first"—a baby-sitting service that was provided for a 50 cent fee per family.

Jefferson County continues on its ever-busy way—not the least of which was its Doctors' Day Dinner and Auction in March at the Steubenville Country Club. "Color It Elegant" was the theme and it was reflected in the beautiful decorations, the menu, the doctors' carnations and the music (the strolling musicians added a very special Bohemian touch!). And the auction added a very special financial touch! Dr. Nick Terezis served as auctioneer and I'm told his enthusiasm and repartee kept the bidding moving amusingly and profitably. There were many unique and interesting auction items contributed by the members.

"Alice in Cardland"

Lucas County's annual money-making project in the form of a Bridge Party was held in April and it was a "Slide Down the Rabbit Hole" at the Sylvania Country Club. Benefiting from this particular project is AMA-ERF as well as other philanthropic projects of the group. The Alice-In-Wonderland theme provided a most provocative emphasis throughout. Another interesting program was held in March not only for the auxilians themselves but for their husbands as well. Dr. Perry MacNeal spoke on "How to Prepare to Retire Gracefully"—an entertaining, thought-provoking and contemporary presentation aimed at all who are too busy and too young to think of retiring! Lucas auxiliary is working on a new concept—from time-to-time programming for both doctors and wives . . . It will be interesting to see how this venture works out! Another money-making March event was the seventh Aesculapian Ball held at the Commodore Perry Ball-room.

Mother-Daughter Banquet

Montgomery County held its annual Mother-Daughter Banquet in March at the Imperial House South and there was something doing every minute. First, there was music and ballet (Peggy and Heidi Albrecht, a talented mother-daughter duo from Montgomery's own medical family, provided this portion of the program). Then Phyllis Colglazier, also from the local auxiliary, shared some of her "apple doll" treasures which she creates herself. And finally Mary Lu Walker from Corning, New York, a nationally known folk singer, captivated her audience with an exciting program. The Montgomery members are hard at work on an Auxiliary Cookbook. There was a Health Careers Day on March 15 attended by some 700 teen-agers. And the group's Christmas card effort netted a whopping \$2,424. The auxiliary has a special "Helping Hands" committee on alert at all times to help in any emergency that might arise in one of its members' families. This is such an excellent way of showing how much the auxiliary really cares!

Scioto County's March meeting was a luncheon at which members were the guests of Mercy Hospital in Portsmouth. James Donaldson, administrator, told of the hospital's newer facilities, notably the coronary intensive care unit and the new exercise facility for cardiac patients. A tour of the hospital followed Mr. Donaldson's talk. The auxiliary's traditional "May Breakfast" was held at the home of Dr. and Mrs. Jerome Rini, at which installation of the new officers was held. Mrs. Jack MacDonald succeeded Mrs. Rini as president.

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PURDUE DEFIBRILLATION CONFERENCE

The Biomedical Engineering Center of Purdue University will hold a conference in Lafayette, Indiana from October I to 3, 1975 covering the practical and clinical aspects of cardiac defibrillation. The speakers have been selected based upon their positions as leaders in their respective fields. The topics to be discussed include clinical, basic science, and engineering aspects of electrical defibrillation as it pertains to the needs of physicians, nurses, emergency medical personnel, hospital engineers, equipment manufacturers, and research scientists. The state-of-the art of defibrillation techniques will be presented and examined critically and a major goal of this three-day conference will be to integrate all available technology for optimization of ventricular defibrillation. The registration fee of \$95 includes proceedings and two luncheons.

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obituaries

Sterling H. Ashmun, M.D., Dayton; Ohio State University College of Medicine, 1916; age 86; died April 8: member of OSMA.

Clyde W. Berry, M.D., Wapakoneta; University of Cincinnati College of Medicine, 1932; age 70; died April 22; member of OSMA.

Joseph Balunis Bolin, M.D., Norwood; University of Cincinnati College of Medicine, 1928; age 74; died April 3; member of OSMA.

Ben L. Boynton, M.D., Panama City, Florida; Northwestern University Medical School, 1936; age 66; died March 22; member of OSMA.

Clinton Howard Buford, M.D., Cincinnati; Meharry Medical College School of Medicine, 1944; age 54; died March 24; member of OSMA.

Kenneth Willis Cook, M.D., Columbus; Ohio State University College of Medicine, 1933; aged 73; died April 18; member of OSMA and AMA.

Ryan Phelps Estes, M.D., Cleveland; University of Texas, Medical Branch, 1922; age 77; died February 10; member of OSMA and AMA.

Harold E. Harris, M.D., Cleveland; University of Iowa College of Medicine, 1936; age 64; died April 25; member of OSMA and AMA.

Talmadge Ray Huston, M.D., Huntington, West Va.; Western Reserve University School of Medicine, 1946; age 54; died in March; member of OSMA and AMA.

Robert Gillis Mossman, M.D., Youngstown; University of Pennsylvania School of Medicine, 1909; age 89; died May 1; member of OSMA and AMA.

Antoine Aziz Khoury, M.D., Cleveland; St. Joseph University, Lebanon, 1951; age 49; died April 6; member of OSMA and AMA.

George Finney Linn, M.D., Norwalk; Ohio State University College of Medicine, 1918; age 82; died April 29; member of OSMA and AMA.

William Foster Lusher, M.D., Temperance, Michigan; Ohio State University College of Medicine, 1960; age 45; died April 11; member of AMA.

John William Means, M.D., Columbus; University of Pennsylvania School of Medicine, 1909; age 88; died March 30; member of OSMA and AMA.

Walter B. Phillips, M.D., Cincinnati; University of Cincinnati College of Medicine, 1931; age 70; died April 1; member of OSMA and AMA.

Earl Hurst Ryan, M.D., Columbus; Ohio State University College of Medicine, 1916; age 90; died April 10; member of OSMA and AMA.

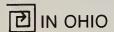
Richard George Schaefer, M.D., Hamilton; University of Cincinnati College of Medicine, 1957; age 43; died in March; former member of OSMA and AMA.

Joseph Dorr Stires, M.D., Malvern; University of Cincinnati College of Medicine, 1928; age 75; died April 22; member of OSMA and AMA.

John Andrew Sommer, M.D., Cleveland; Western Reserve University School of Medicine, 1921; age 78; died April 15; former member of OSMA and AMA.

Joseph Daniel Vande Velde, M.D., Lakeside; Ohio State University College of Medicine, 1934; age 66; died April 20; member of OSMA and AMA.

CONTINUING



Case Western Reserve University For further information: School of Medicine 2109 Adelbert Road Cleveland 44106

Ear, Nose & Throat and the Practicing Physician; October

25th Annual Scientific Assembly—Ohio Academy of Family Physicians; August 1-3; Sheraton-Columbus Hotel, Columbus; contact: OAFP, 4075 North High St., Columbus 43214; clinical sessions acceptable for 13 prescribed postgraduate hours by the American Academy of Family Physicians.

AMA Congress On Occupational Health; September 29-30; Cincinnati; contact: AMA's Dept. of Environment, Public and Occupational Health, 535 N. Dearborn St., Chicago, Ill. 60610; registration fee is \$30.

Family Practice Refresher; October 20-24; sponsored by Ohio Academy of Family Physicians; Holiday Inn, 328 W. Lane Ave., Columbus; contact: OAFP, 4075 North High St., Columbus, 43214; \$250 for physicians; \$150 for family practice residents; acceptable for 40 prescribed postgraduate credit hours by American Academy of Family Practice.

OUTSIDE OHIO

Critical Care—A Postgraduate Course in Clinical Assessment for Nurses and Physicians; June 23-25; Hyatt Regency Hotel, Nashville, Tenn.; sponsored by the American College of Chest Physicians; approved for 17 hours of AMA Category 1 credit; \$115 for physician members; \$140 for non-members.

Clinical Oncology: Breast Carcinoma; July 16-19; Waterville, Me.; co-sponsored by American College of Physicians, American Assn. for Cancer Education, and American Society of Hematology; contact 4200 Pine St., Philadelphia, Pa. 19104; approved for AMA Category 1 credit.

Current Concepts in Radiology; July 21-26; Atlantis Lodge, Atlantic Beach, N.C.; contact: Robert McLelland, M.D., Dept. of Radiology, Duke University Medical Center, Durham, N.C. 27710; approved for 30 hours of AMA Category 1 credit.

Expanding Role of the Diagnostic Radiological Physicist; July 27-August 1; Rice University, Houston; Sponsored by American Association of Physicists in Medicine; contact: Stewart C. Bushong, Baylor College of Medicine, Houston, Tex. 77025; \$175 for AAPM members; \$250 for non-members.

Aspen Mushroom Conference; August 11-15; Hotel Jerome, Aspen, Colorado; contact: 3300 South Wabash Court, Denver, Colo. 80231, (303) 755-2588.

Hypertension 1975; June 26; University of Kentucky Medical Center, Lexington, Kty.; contact: Frank R. Lemon, M.D.; \$20.

Cardio-Pulmonary Emergencies; June 27-28; University of Kentucky Medical Center, Lexington, Kty.; contact: Frank R. Lemon, M.D.; \$75.

Histologic Diagnosis of Inflammatory Skin Diseases—Alumni Hall, NYU Medical Center, 550 First Ave., New York, N.Y.; June 26-28; fee is \$200; for residents \$100; contact: Office of the Associate Dean, New York University Post-Graduate Medical School, 550 First Avenue, New York, New York 10016.

Current Concepts in Radiology Including Diagnosis, Therapy and Nuclear Medicine—Atlantis Lodge, Atlantic Beach, North Carolina; July 21-26; fee is \$150; contact: Robert McLelland, M.D., Dept. of Radiology, Box 3808, Duke University Medical Center, Durham, North Carolina 27710.

Purdue Defibrillation Conference—Lafayette, Indiana; October 1-3; fee is \$95; contact: Division of Conferences and Continuation Services, Stewart Center, Purdue University, West Lafayette, Indiana 47907.

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NO. 8



Original and Scientific Articles

CORTICAL EXCISION AS A SUPPLEMENTARY TREATMENT FOR EPILEPSY George W. Paulson, M.D.; Martin P. Sayers, M.D.; and 459 Robert Calhoun, B.S., Columbus

SOME UNRESOLVED QUESTIONS REGARDING EMERGENCY DEPARTMENT PHYSICIANS 463 Oscar P. Hampton, Jr., M.D., St. Louis, Missouri

A NEW ACNE CLEANSER K. William Kitzmiller, Cincinnati 467

Special Articles

524 A LOOK AT HISTORY - OUR MEDICAL HERITAGE An introductory article for The Journal's Bicentennial Series. By Richard L. Meiling, M.D.

AN INSIDE LOOK AT THE MEDICAL BOARD 516 OSMA concludes its interview with William J. Lee, Administrator of the Ohio State Medical Board.

1975 Annual Meeting

PRESIDENT'S ADDRESS	471
NEW OFFICERS ELECTED	479
AUXILIARY REPORT	483
INDEX TO RESOLUTIONS	489
ATTENDANCE OF DELEGATES	490
PROCEEDINGS OF THE HOUSE OF DELEGATES	492
ANNUAL MEETING ATTENDANCE	511

Features

News	452	Woman's Auxiliary	515
Comments	444	Continuing Education	454
Ohio Health News	456	Obituaries	521
The Federal Scene	451	Journal Advertisers	530
Council Minutes	510	Classified Ads	531
New Members	522		

ABOUT THE COVER: The Ohio Land Company was formed in 1786. Its members, mostly Revolutionary War Veterans from New England, were determined to found a new "state" between Lake Erie and the Ohio River. Following a territorial period, Ohio became a state when Congress passed the Enabling Act in 1802. With this issue, The Journal begins a Bicentennial series of articles examining our medical heritage. The series' first article is on page 524.

comments

Health Revenue Sharing

The U.S. House of Representatives took action on The Nurse Training Act of 1975 and the National Health Services Corps Act of 1975 by enacting another piece of legislation — the Health Revenue Sharing and Health Service Act of 1975.

The provisions of the three acts were then incorporated into Senate Bill S.66 and passed. A conference between House and Senate was requested to resolve differences in the combined bills as passed by the two chambers.

The price tag on the National Health Service Corps for one year is 16 million dollars. One provision is a subsidy, not to exceed \$1000 per month, for physicians or dentists in the National Health Services Corp who practice in an "under-served" area. The subsidy is applicable for 36 months or as long as the individual is engaged in delivering health service in a designated geographical area.

Approximately \$560 million is the price tag on the Nurse Training Act, which includes capitation grants, construction grants, and a loan program. The capitation for an undergraduate studying in a "collegiate school of nursing" will be \$400 per student/per year. For those in an "associate degree" program \$275 per student/per year will be given. Finally, a diploma School of Nursing will receive \$250 per student/per year.

Also under the Nurse Training Act, the Secretary of Health, Education and Welfare will determine the supply of Registered Nurses, Licensed Practical Nurses, Vocational Nurses, Nurses Aides, Nurse Practitioners, nurses with graduate degrees and nurses with advanced training. Data concerning the distribution of nurses within each state, the demand for nursing service in a state, the average rates of compensation, and the status or activity of each category of nurse in the United States must be reported to Congress annually.

The Health Revenue Sharing legislation involves many areas: Family Planning Program, Community Mental Health Centers, Migrant Health Authority, Community Health Centers, Home Health Care, and Service Agencies. It also involves a Commission on Control of Epilepsy, Committee on Mental Health and Illness of the Elderly, and Commission on Control of Huntington's Disease. Finally, this legislation covers calls for establishing a comprehensive diagnostic and treatment center for hemophilia and expanding blood separation centers.

Physician Salaries

H.R. 6088 would increase Veterans Administration physician and dentist salaries from the present \$36,000 up to \$75,000 per year. (I assume that is for the current federal government 40-hour week.)

The AMA Board supported provisions of this bill in testimony before the House Veterans Affairs Subcommittee on Hospitals. The administration opposed the provisions which would raise the salaries and suggested a bonus program similar to that available to physicians in the armed services.

Is a forty-hour week in a Veterans Administration facility in United States communities comparable to duty in an Army hospital in Tehran, Iran? At an Air Force hospital in Thule, Greenland? Or at a Navy Medical Research Station in Cairo, Egypt? Is it comparable to duty served by military physicians in the last several months in the Saigon evaculation, or in Bankok, Turkey, or Greece?

Perhaps the Veterans Administration medical program and its medical education programs need scrutiny. Perhaps the programs need reorientation toward "health care delivery" systems available to the "total population" rather than a limited segment—i.e. the veteran.

When the Veterans Administration Hospital and Clinic program was formulated, the military service personnel and veterans did not have Social Security coverage with Medicare and Medicaid. Today Social Security covers the veteran as it does his fellow citizen. Therefore, we need a 1975 look at the total problem.

-Richard L. Meiling, M.D.

Limiting Medicare Reimbursement

The administration's proposal to lower the level of Medicare reimbursement from the 90th percentile to the 80th will almost certainly lower the income of teaching hospitals. This will adversely affect both undergraduate and post-doctoral medical education programs based in teaching hospitals.

The AMA objected to proposed regulations limiting inpatient service costs under Medicare, based on estimates of the necessary cost of efficient delivery of needed health services for individuals covered by the medicare program. (See 223, 1972 Social Security Act Amendments).



al scene

Health Manpower Legislation

The AMA urged all U.S. Congressmen to oppose two key provisions of the 1975 Health Manpower Bill (H.R. 5546) that would extend federal control over medical education. Ohio Congressmen have been similarly urged by OSMA.

The controversial sections of H.R. 5546, which passed easily in the House Interstate and Foreign Commerce

Committee, would:

• Establish federal control of the types, number and location of medical specialty residencies.

• Require all medical students to repay the federal government capitation grants for U.S. aid to their school, during the period the student was enrolled.

The bill authorizes \$1.7 billion for aid to medical, dental, nursing and other schools with a \$2,100 per student capitation subsidy by the federal government for medical students.

If the House votes favorably on H.R. 5546, the Senate will then consider it along with six other Health Manpower Bills. Senator Kennedy (D.-Mass.) introduced four of the Senate bills. A House vote is expected about midsummer. All attempts by the AMA, American Association of Medical Colleges, and American Hospital Association to amend H.R. 5546 in committee were fruitless.

In a letter to the 435 Congressmen, the AMA stressed continued support for federal assistance to medical schools and students. However, the Association said "strong objection is raised" to "certain new concepts" that would impose restrictions on students and on residencies.

The AMA told House Members:

"These requirements—that the students, as a personal obligation, repay to the federal government those amounts for capitation grants which the government has given to the schools—are without precedent and are discriminatory against health professions' students. These conditions are not imposed on students in other fields, nor should they be.

This amounts in effect to a forced loan required of all health professions' students under the bill. Once again, through the service requirements attached to the loan forgiveness features, the low income or disadvantaged

student would carry a disproportionate burden."

"The best way to attract individuals to shortage areas," according to the AMA, "is through mechanisms which allow the individual voluntarily to commit himself to service in a needy area. As to government programs, this could be done through such programs as the National Health Service Corps, scholarships for service in shortage areas, loan forgiveness, or other incentive programs.

"It should not be done through a program where all students are under the burden of insuring that the federal assistance given to the school is repaid by the student," the AMA said. The proposed control of medical residency training programs amounts to "the rationing of medical education . . . and poses many threats to our quality edu-

cation system."

H.R. 5546 would establish two agencies: one responsible for accrediting medical residency training programs in the U.S.; the other to establish the number of positions which could be filled in each residency program.

The aggregate limit on the number of positions which could be available in years 1978, 1979, and 1980, would be an amount equal to 155 percent, 140 percent and 125 percent, respectively, of the estimated number of graduates from accredited U.S. schools of medicine in the vear preceding.

Priority for designation would be the Liaison Committee for Graduate Medical Education of the Coordinating Council on Medical Education (CCME) as the accrediting agency, and the CCME as the agency to estab-

lish the number of residency positions.

The CCME would determine the geographical distribution of residency training positions, the number of positions in each program, and an allocation of positions among the various specialties. In the absence of designation of the named agencies, the activities would be undertaken by another organization designated by the HEW Secretary.

If the sweeping service requirement of the bill is retained, the impact on American medical practice would be marked with more than 10,000 young physicians yearly heading into rural areas, inner-city slums, and other shortage areas. Furthermore, the federal government—military, public health service and Veterans Administration—would have recruiting worries erased by qualifying as an "area of need" for obligated service.

A portion of the material above was from "Washington News", a monthly summary prepared by the AMA's Washington office.

State Univ. Hospitals May Be Able To Buy Insurance

A bill allowing state owned and operated teaching hospitals to purchase "medical-professional liability insurance" has passed the Ohio Senate on June 10. Passing by a margin of 31-0, the bill permits hospitals to purchase insurance for students, interns, residents, nurses, employees and other agents of the hospital.

The bill was sent to the House for immediate consideration. If, as anticipated, this legislation is approved by the House and Governor Rhodes, it will enable hospitals such as The Ohio State University Hospital to retain interns and residents. In the present marketplace, these interns and residents have been unable to purchase professional liability insurance. The bill will thus protect and advance the educational programs of university hos-

As of July 3, the bill was signed by Governor Rhodes.

Supreme Court Improves System For Disciplining Ohio Attorneys

The Ohio Supreme Court has adopted three rules providing for faster and more thorough investigation of complaints against lawyers and judges. The rules require biennial registration of attorneys, create a new agency to conduct investigations, and insure adequate financing for the improved disciplining system.

The rules were made as amendments to The Supreme Court Rules for the Government of the Bar of Ohio. The Supreme Court is the only agency authorized to impose discipline for misconduct upon a lawyer or judge in Ohio.

One of the new rules requires every attorney at law admitted to practice in Ohio to file a Certificate of Registration every two years, paying a \$35 fee per year. The first Certificate of Registration will be filed on or before November 1, 1975. Thereafter, certificates will be filed in each odd-numbered year beginning in 1977. Any attorney who does not register and pay the required fee cannot practice law in this state.

A second rule establishes a new agency to conduct investigations of alleged misconduct of lawyers and judges. Effective in January, 1976, the Supreme Court will appoint a Disciplinary Counsel and Assistant Disciplinary Counsel. The appointees must be attorneys admitted to practice in Ohio, although they cannot practice privately while holding these positions.

If the Grievance Committee of a local bar association or the Ohio State Bar Association's Committee on Legal Ethics and Professional Conduct finds that a complaint they are investigating is sufficiently serious or complex, they will refer the matter to the Disciplinary Counsel. The Disciplinary Counsel will investigate the complaint and report the results to the committee which referred it.

Funds for the Disciplinary Counsel and staff will come from the \$35 registration fee. The Supreme Court said that it "strongly believes the taxpayer should not be asked to finance the disciplining of lawyers and judges, rather the profession of law should clean up its own house and pay for the cleaning up."

The Disciplinary Counsel will file an annual report describing activities, accomplishments, and expenses.

The Supreme Court said the only serious flaw in the present system of lawyer discipline is the span of time from when a complaint is filed until a hearing is held and discipline imposed. Therefore, the third new rule adopted by the Supreme Court requires that investiga-

tions of complaints by the state or local bar associations be concluded within sixty days from when the complaint was made. A decision on the complaint must then be made within 30 days. If an investigation is not completed within 150 days, the matter will be referred to the Disci-

plinary Counsel.

Beginning in January 1976, the state and local bar associations must file a quarterly report with the Disciplinary Counsel. The report will indicate the number of complaints filed, the number pending in each category of alleged misconduct (commingling of funds, conviction of crime, failure to file income tax returns, failure to protect a client's interests, soliciting, embezzlement, conversion, failure to account, excessive fees, mental illness, etc.), and the number terminated by action of the committee.

When he announced the new rules, Chief Justice O'Neill said: "The purpose of lawyer discipline is to protect the public from misconduct of unethical lawyers and judges. It is not to punish lawyers and judges. This is the task of criminal law."

OSMA Awards Doctors For Best Scientific Exhibits

A scientific exhibit entitled "Fluorescent Microscopy of the Injured Blood-Brain Barrier" won OSMA's first award for Original Research. W. Michael Vise, M.D., of Columbus created the exhibit.

Nine scientific exhibits created by Ohio physicians won awards during OSMA's 1975 Annual Meeting. A total of 26 scientific exhibits were on display for those participating in the meeting held in Columbus two months ago.

The awards, given annually, are divided into five categories: Original Research, Clinical Investigation, Teaching, a Special Award, and a Cancer Award. Following is a list of the winners and their exhibits:

Original Research

1st — Fluorescent Microscopy of the Injured Blood-Brain Barrier. By W. Michael Vise, M.D., of Columbus.

Clinical Investigation

1st — The Reconstruction of Veins. E. A. Husni, M.D., and M. Bakhos, M.D., of Cleveland.

2nd — Intraoperative Autotransfusion: Simple, Economical and Practical Approach to Blood Replacement During Surgery. Stephen M. Cattaneo, M.D.; James A. Blackford, M.D.; Bruce A. Radcliffe, C.T.; Frederick Lacey; and Gary Lageman, C.T.; all of Columbus.

3rd — Clean Air in Total Hip Replacement. Thoms H. Mallory, M.D.; and David Halley, M.D., both of Columbus.

Teaching

1st — Cervical Spondylosis. Stewart B. Dunsker, M.D.; and Frank H. Mayfield, M.D., both of Cincinnati.

2nd — Geometric II Knee Replacement Arthroplasty. Alan H. Wilde, M.D.; H. Royer Collins, M.D.; John A. Bergfeld, M.D.; and A. Seth Greenwald, D. Phil (Oxon) of Cleveland.

3rd — Doppler Ultrasound in Peripheral Vascular Surgery. Steven M. Dosick, M.D.; William S. Blakemore, M.D.; Donald Woodson, M.D.; and J. Robert Navarre, M.D., all of Toledo.

Special Award — Gold

Cervical Spondylosis, by Stewart B. Dunsker, M.D. and Frank H. Mayfield, M.D. (Cincinnati).

Cancer - \$300 Award

Breast Cancer Management, John Peter Minton, M.D., of Columbus.

Certificates of Merit were given to 12 scientific exhibits:

Comprehensive Management of Epilepsy. (Baltimore, Maryland), Samuel Livingston, M.D.; Lydia L. Pauli, M.D.; Irving M. Pruce, B.S.; and Herbert L. Livingston, D.D.S.

Anti-inflammatory Therapy in Rheumatoid Arthritis Complicated by Upper Gastrointestinal Disease. (California), Sanford H. Roth, M.D.; DeWitt W. Englund, M.D.; Benjamin K. Harris, M.D.; and H. Arlene Ross, M.D.

Two New Concepts of Acute Gastroenteritis.

H. Juhling McClung, M.D., of Columbus.

Trigeminal Neuralgia: A New Surgical Approach. John M. Tew, Jr., M.D.; and Frank H. Mayfield, M.D., of Cincinnati.

Reconstructive Breast Surgery. H. William Porterfield, M.D.; Lester R. Mohler, M.D.; and James

W. Ferraro, D.D.S., M.D., all of Columbus.

Management of Erythroblastosis Fetalis. Leandro Cordero, M.D.; Colin MacPherson, M.D.; and

William Rigsby, M.D., all of Columbus.

If You Think It Could Be Mono. Francis W. Eberly, M.D.; and Thomas D. Stevenson, M.D. (Columbus).

Halcinonide — A New Treatment for Psoriasis.
Marvin I. Lepaw, M.D. (New York).

Marvin I. Lepaw, M.D. (New York).

Evolving Concepts of Sjogren's Syndrome. Arthur L. Scherbel, M.D.; Allen H. Mackenzie, M.D.; Constance S. White, M.D.; John D. Clough, M.D.; and Raymond J. Scheetz, M.D. (Cleveland).

E.P.S.D.T. Screening in Rural-Suburban Ohio. Albert N. May, M.D.; and Ellen Weaver, P.A. (Marion).

Early Diagnosis and Early Treatment of Spine Deformity. N. J. Giannestras, M.D.; and Bernard B. Bacevich, M.D. (Cincinnati).

Trans-areolar Augmentation Mammoplasty.

John L. Terry, M.D., Columbus.

Juding the awards was a committee of four OSMA members: Jerry L. Hammon, M.D., West Milton, a member of OSMA's Committee on Scientific Work; Thomas W. Morgan, M.D., Gallipolis, Ninth District Councilor; James C. McLarnan, M.D., Mt., Vernon former Tenth District Councilor; and James G. Tye, M.D., Dayton, former Second District Councilor.

AMA Wins

Preliminary Injunction

Against HEW

A Federal Judge in Chicago granted preliminary injunction to stop HEW from enforcing or implementing utilization review regulations for Medicare and Medicaid patients. The injunction, granted on May 27, resulted from AMA's suit filed against the Department of Health, Education and Welfare last February.

The utilization review regulations were first scheduled to take effect on February 1, 1975. The AMA is now seeking a "permanent injunction" against HEW's en-

forcing these regulations.

U.S. District Court Judge Julius J. Hoffman stated that there is "evidence to suggest that the proposed (HEW) regulations violate that portion of the Social Security acts which forbids Federal supervision or control over the practice of medicine."

CONTINUING EDUCATION

回 IN OHIO

Case Western Reserve University For further information: School of Medicine 2109 Adelbert Road Cleveland 44106

Ear, Nose & Throat and the Practicing Physician; October

What's New In Pediatrics: Sam Spector Day; November 12; Case Western Reserve University, Pediatric Clinical Faculty, Fifth Annual Symposium. Subjects: Current and future developments in medical care of children; immunology, neonatology, hematology, and respiratory disease. Faculty: Samuel Spector, M.D., Samuel Gross, M.D., Avroy Fanaroff, M.D., Carl Doershuk, M.D., Stephen Polmar, M.D., Marshall Klaus, M.D., no fee. Contact: S. S. Strassman, M.D., Pediatric Dept., Rainbow Babies and Childrens Hospital, University Circle, Cleveland, 44106.

25th Annual Scientific Assembly—Ohio Academy of Family Physicians; August 1-3; Sheraton-Columbus Hotel, Columbus; contact: OAFP, 4075 North High St., Columbus 43214; clinical sessions acceptable for 13 prescribed postgraduate hours by the American Academy of Family Physicians.

Ninth Annual Urology X-Ray Seminar; December 7-9; Stouffer's Cincinnati Inn; Contact: Arthur T. Evans, M.D., Div. of Urology, University of Cincinnati Medical Center, 231 Bethesda Ave., Cincinnati, 45267.

AMA Congress On Occupational Health; September 29-30; Cincinnati; contact: AMA's Dept. of Environment, Public and Occupational Health, 535 N. Dearborn St., Chicago, Ill. 60610; registration fee is \$30.

Neurological Syndromes Associated with Cancer: Robert Reed, M.D.; Current Concepts in Tumor Immunotherapy: Albert Lobuglio, M.D.; Current Concepts in the Treatment of Breast Caner: John Minton, M.D.; State of the Art in Cancer Chemotherapy: Richard L. Meyer, M.D., Oct. 2; Sponsored by the Tumor Registry Committee of the Medical and Dental Staff of the Good Samaritan Hospital, Cincinnati, 45220.

Family Practice Refresher; October 20-24; sponsored by Ohio Academy of Family Physicians; Holiday Inn, 328 W. Lane Ave., Columbus; contact: OAFP, 4075 North High St., Columbus, 43214; \$250 for physicians; \$150 for family practice residents; acceptable for 40 prescribed postgraduate credit hours by American Academy of Family Practice.

Purdue Defibrillation Conference—Lafayette, Indiana; October 1-3; fee is \$95; contact: Division of Conferences and Continuation Services, Stewart Center, Purdue University, West Lafayette, Indiana 47907.

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OUTSIDE OHIO

American Cancer Society's National Conference on Gynecologic Cancer: Sept. 18-20; Marriott Hotel—Philadelphia, Pa.; 15 credit hours in Category I for the Physician's Recognition Award of the AMA, and 15 Elective Hours by the American Academy of Family Physicians; contact: Sidney L. Arje, M.D., American Cancer Society, 219 E. 42nd St., New York, N.Y. 10017.

Recent Advances in Clinical Anesthesia; Sept. 27-28; sponsored by the department of anesthesiology of New York University Medical Center; 13 credit hours in Category I for the Physician Recognition Award of the A.M.A. Tuition is \$60: residents in training, \$80.; contact: Office of the Associate Dean, New York University Post-Graduate Medical School, 550 First Ave., New York, N. Y. 1003. Phone: (212) 679-3200, ext. 4027.

Radiology of the Urinary Tract; Sept. 8-12; Contact: Continuing Medical Education, 1350 Mayo, Box 293, 412 Union St. S.E., Minneapolis, Minn. 55455.

Planning of Radiological Departments; Sept. 26-30; Sponsored by Temple University and ACR Committee on Department Planning. A.M.A. Category I credit applied for. Contact: Francis J. Shea, M.D., Dept. of Radiology, Temple University School of Medicine, 3401 N. Broad St., Philadelphia, Pa. 19140.

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John H. Ackerman, M.D., M.P.H.

Director of Health

Treatment Costs For Hemophiliacs Cut

An Ohio Department of Health plan to cut treatment costs for hemophilia victims has won coverage under Blue Cross and Blue Shield plans. Previously, the plans covered hospital treatments only. Under the new program, persons suffering from hemophilia and some members of their families will be trained to administer certain treatments at home in event of a bleeding episode.

Earlier this year, I had designated the following hospital to serve as hemophilia centers: Toledo Hospital, Cleveland Metropolitan General Hospital, Rainbow Babies' and Children's Hospital in Cleveland, Columbus Children's Hospital, Good Samaritan Hospital in Cincinnati, Children's Medical Center of Dayton, and Children's Medical Research Foundation in Cincinnati.

Blue Cross and Blue Shield plans will make payments to hemophilia centers appropriate coagulants and other necessary supplies used in the home treatment program.

In order for Blue Cross and Blue Shield plans to reimburse the hospitals for services under this program, the following conditions must be met:

- A complete history, physical examination and appropriate X-ray and lab studies are to be performed on each hemophiliac candidate prior to entrance into this program. It should be noted that while these procedures are recommended, Blue Cross and Blue Shield plans will make payments for the specific items only when the existing subscriber contract provides coverage. (Certain contracts in which provisions are a result of negotiation specifically exclude payments for this service.)
- The hemophiliac and his family must be exposed to a lecture on the theory of hemophilia treatment, available preparations, and the advantages and disadvantages of the therapy. The Blue Cross and Blue Shield plans will request a certification from the hospital center program that the patient and his family have been indoctrinated in the techniques of home infusion.
- If the hemophiliac patient and his family indicate a
 desire to participate in a home care program, a physician associated with the hospital center must certify
 the patient as a suitable candidate for home care
 an evaluation based on considerations listed elsewhere.
- Once those members of the family or the hemophiliac are approved for this infusion program, they must then be instructed on the sterile techniques and venipunctures to become familiar with the procedure. They must also become familiar with the various coagulants, including requirements for storage of products and possible reactions to the infusion of such products. The certification described in Item 2 above will include

confirmation of the family also being aware of the appropriate sterile technique.

- Once these training and familiarity exercises have been completed, a supply of the designated coagulant will be issued to each patient to cover bleeding episodes. Necessary supplies would be obtained from the hospital center.
- The initial infusions under this program by the hemophiliac or his family would be performed at the designated hospital center and infused under the supervision of the hospital center program.
- The family of the patient would then be allowed to begin home therapy upon demonstrating competence and on approval of the physician in charge of the hospital center program.
- After the patient starts to use the home treatment program, there shall be notification of each bleeding episode to the hospital center program. Data on all patients receiving care under the hemophilia home health program must be maintained by the hospital center for a period of at least three years and be made available upon request to Blue Cross and Blue Shield plans for analysis.
- These records of infusion must be reviewed and approved by the hospital center before additional coagulants and supplies would be replenished.
- A physical examination not less than annually will be required of the hemophiliac to determine the patient's progress.
- All claims submitted to the Blue Cross and Blue Shield Plans of Ohio in connection with this program will be subject to review to determine the reasonableness of charges.

Twelve persons have been appointed to the Ohio Comprehensive Health Planning Advisory Council for terms effective immediately. All but one were appointed for terms ending March 26, 1978. Named were Murray Stein, D.D.S., of Cleveland; Sam Bassitt, Lima; Robert J. Corts, Elyria; Wilma Garverick, Mt. Gilead; Keith McNamara, Columbus; Suzanne C. Moulton, Gallipolis; Joyce C. Young, Dayton; Marion C. Anderson, M.D., Toledo; Matthew M. Brown, Springfield; Dale Hollern, Columbus; and John W. Schenz, D.O., Columbus. Jack T. Fisher of Wooster was appointed for a term ending March 26, 1976. The Director of Health has the authority with the approval of the Governor to establish and appoint advisory boards to aid in the conduct of work in the Department. The 39-member planning advisory council meets every other month.

Cortical Excision as a Supplementary Treatment for Epilepsy

George W. Paulson, M.D. Martin P. Sayers, M.D. Robert Calhoun, B.S.

> Surgical therapy as an adjunct procedure in the treatment of patients with persistent epileptic convulsions.

THOUGH MOST SEIZURE DISORDERS can and should be managed by family physicians, the neurologists and the neurosurgeons often see patients with intractable convulsions. During the 1950s, several new anticonvulsants appeared, but in the past decade there has been a disappointing lack of new therapies for epileptologists to use. Medications currently used in Europe but not yet released in the United States eventually may become available, but it is likely that specialists will continue to confront some patients who are incapacitated by persistent, abnormal, electrical discharges which lead to clinical seizures. An old technic for some of these patients, used for over 50 years, consists of the removal of irritable cortical foci in order to control seizures; and there are reports of several large series of patients from the National Institutes of Health and the Neurological Institute in Montreal.^{1,2} It is less well known that in some community hospitals, and in most university hospitals, selected cases of epilepsy can be treated by cortical excision, and that such surgery occasionally leads to dramatic improvement. Failures with drug management should remind the physician to consider surgery as ancillary therapy.

This article is a report of one such experience. and reviews indications, complications, and expectations from the utilization of surgery for the control of seizures.

Case Reports

Case 1.—This 37-year-old housewife has had temporal lobe and grand mal seizures since the birth of her first child 20 years earlier. Her seizures were as frequent as four to five complex psychomotor discharges per week, and lasted for three to six minutes. Usually the seizures were brief episodes of eye fluttering with clonic jerks of her upper limbs. She had had only four to five major or grand mal seizures per year, but there were numerous abortive minor seizures daily. A prominent left temporal spike and slow wave discharge had been noted on most electroencephalograms (EEGs) since the onset of the illness. Physical examination was generally unremarkable, but she was considered emotionally unstable

and was overtly paranoid and demanding.

At time of surgery, a left frontoparietal bone flap was turned down and recording from the surface of the cerebrum was effected. The cortical electrodes were relatively silent but the depth electrode showed a focus at 5-cm deep in the temporal lobe. Resection of the anterior three-fifths of the left temporal lobe was carried out uneventfully. The brain tissue felt abnormally firm to the surgeon. Neuropathologic microscopic studies revealed focal areas of acute interstitial hemorrhage and mild gliosis. She had minimal aphasia for several days follow-

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ing the surgery. In the year following surgery, the patient remained paranoid and still did not give an adequate history, but according to her husband, she had no additional seizures and the dosage of anticonvulsant had been reduced.

Case 2.—A 16-year-old girl became epileptic after a severe head injury at 10 years of age. After this, she had intractable seizures despite the use of high doses of various combinations of the common anticonvulsants. The seizures consisted largely of brief lapses of awareness, were occasionally adverse in character, and occurred frequently each day. A right temporal epileptogenic focus was recorded on three routine EEGs.

Pneumoencephalograms revealed some atrophy of the middle portion of the right lateral ventricle, and after 10 years of evaluation and repeated failure to control the seizures, surgery was scheduled. Electrocortography revealed frequent seizure discharges in the right frontalparietal area with sporadic spikes posteriorly. The temporal lobe was relatively silent. Approximately 10 gm of cerebral cortex just in front of the motor strip was resected, lateral to the interhemispheric fissure. Immediately after excision, electrocortical activity quietened a great deal, though occasional focal spikes were still seen in the EEGs after surgery. Neuropathologic microscopic studies of the tissue removed revealed no abnormalities. She improved dramatically following surgery and has had no convulsions in 18 months of follow-up.

Case 3.—This 38-year-old white man experienced a right subdural hemorrhage in infancy, and was operated on for it at that time by a neurosurgeon, who noted major cortical damage. In the years after surgery, his left leg was smaller and by age 8 years, he had developed frequent left focal seizures which were never controlled. He continued to have from three to five seizures each week, usually manifested by muscle spasms and brief loss of consciousness. Pneumoencephalogram and repeated EEGs showed a sharply localized area of disturbance in the right frontal-temporal area. Brain scan was always normal. Following a decade of trial of various medications, he had a right frontoparietotemporal craniotomy and electrocortography which led to resection of a large epileptogenic focus in the premotor area of the right hemisphere. Following surgery, the patient improved with a reduction in seizures, and those seizures that still occurred were less intense. He tolerated his medication wall but despite adequate does he continued to have well, but despite adequate doses, he continued to have as many as two minor seizures per week.

Case 4.—This 22-year-old man had three or four major or minor focal left-sided seizures per week despite high doses of most of the usual anticonvulsants. Although the seizures limited his life, he continued to be gainfully employed. A large irritable focus was recorded at electrocortography in the midportion of the right frontal lobe. A major area of arachnoidal and cortical scar was nearby but did not overlap with the irritable area. An area 5 cm in diameter was resected. The neuropathologic microscopic report was not revealing. He was seizure-free one year after surgery and had applied for a driver's license at that time.

Experience in Our Group

During the past 15 years, over 25 patients in our group have been operated upon, fortunately, with no mortality. Although it is not possible to adequately summarize the results of each of these patients because some have been lost to follow-up, approximately 20 had a marked reduction or complete control of seizures for up to three or four years after cortical excision. In each case operated upon, local seizure phenomena was recorded both electrocortographically and clinically. Both recording and surgical technic remained the same during this period of time. After attempts for several

years to control the patient's seizures by medication, invariably using multiple medications, each patient received special contrast studies as indicated, including pneumoencephalography in each case. Usually, focal ventricular dilatation could be seen. Several cases had extreme destruction of one hemisphere, and a hemispherectomy was performed in these cases. In most cases, areas of cortical scarring with thick, white, arachnoidal membranes or palpably firm tissue were found.

Electrocorticographic recordings utilized primarily the monopolar system, and in most cases, an area of maximal cortical irritability could be identified easily although it was rare that surrounding tissue was not also involved to some degree. The excitable tissue usually was not in the exact area of scar, but often was anterior to it. Patients were anesthetized during the procedure, but anesthesia was kept as light as consistent with comfort. After identification of the area of maximal electrical irritability, markers of sterile string were used to outline the margins of the electrically excitable area which was then resected via standard neurosurgic technics, with preservation of vital areas and of key blood vessels. The cortical resection was down to and included some white matter, and there was electrocorticographic recording of the margins after cortical excision. In almost all cases, there was marked suppression of electrical activity following the excision, largely due to the effects of surgery. In some cases, however, additional areas of spike discharge could be identified, and when this was prominent and persistent, further cortical excision usually was performed. A combination of surgical and electroencephalographic data and judgment was desirable when additional surgery was necessary. Occasionally, a transient and clinically inconsequential spike is generated temporarily in the margin of the new scar right after surgery or unsuspected foci can become apparent. Usually, the initial excision with slight supplementary excision was all that was performed. Tissue that was atrophic or obviously severely scarred generally was removed also.

In the postoperative phase, the patient was maintained on his usual anticonvulsants and was followed with slow reduction of medication over the months after surgery whenever this was feasi-

Fortunately, there has been no mortality, and no permanent clinical deficit that could be attributed to the surgery. Several patients had transitory weakness or speech difficulties in the first week after surgery, invariably when surgery was close to the crucial area involved. In all patients, return to at least the preoperative state was apparent within a month.

Depth electrodes were used for additional electroencephalographic recordings within

hemisphere on numerous occasions, but frequently they did not affect the surgical approach significantly even though a deep focus could be located occasionally. Such foci are often inaccessible without harm to the patient, and at times may reflect a second focus rather than the primary one. We have not noted exacerbation of a seizure focus in the opposite hemisphere once a unilateral focus was excised.

The greatest weakness in our observations is the lack of adequate follow-up, though all of the patients have been seen by the primary neurosurgeon on more than one ocassion in the months following surgery. There is not sufficient data available to summarize changes in electroencephalograms after surgery.

Selection of Cases

Obviously, the fundamental consideration in surgery for seizure control is the selection of cases. The literature emphasizes the predominance of temporal lobe foci in cases suitable for surgery. Many of the larger series are contaminated by patients with primarily psychologic problems, extreme behavior, or motor disturbances, and in some series, the surgery was actually for behavioral modification.³ In some series, patients received several weeks of depth recordings prior to surgery in order to combine research efforts with attempts to localize a deep focus for excision. In these cases, it is possible that research goals or the trauma of the electrodes themselves obscured clinical results.

The patient who is most likely to be benefited by surgery is clearly the patient who has a *focal* seizure disorder about which there is no question as to severity or location, and when there is no doubt about the patient's ability to withstand surgical excision and to benefit from a reduction in seizures.

Different anticonvulsant drugs are available in different parts of the world. The certainty that the patient has had an adequate drug trial depends upon what is available as well as the individual physician's concepts of adequate drug trial. At the least, the patient should have been followed before surgery by a physician with a particular interest in seizure control, and in general, at least three drugs should have been tried in therapeutic doses. Drug trials usually will have extended over a period of years rather than months.

Although most neurologists and neurosurgeons use the general dictum that anticonvulsant medication should be pushed either to the point of relief of seizures or to the point of toxicity, it is our opinion that extreme toxicity due to the drugs can be as bad as the seizures themselves. Nevertheless, high doses and multiple drugs are

necessary in difficult cases. In addition to a sustained, high-level use of multiple drugs, and a long period of observation, one must be certain also that the patient is taking the medication prescribed. The ready accessibility of opportunities to check blood levels makes confirmation of the serum level easier now. In almost all cases when seizures are very common, the patient does take his medication regularly. The patients reported in this manuscript have all been seen by more than one specialist. Consultations between neurologist, neurosurgeon, electroencephalographer, and psychiatrist are often helpful in cases that require surgical therapy for seizures.

In addition to certainty that drugs have been utilized efficiently and consistently before surgery, the focal character of the seizures must be emphasized. Many seizures with generalized appearance will have a focal onset, though it is not our opinion that all generalized seizures have some type of focus initially in the first few microseconds. A reliable and completely valid focus is best demonstrated by the clinical features of the seizure; but must also be confirmed by persistent electroencephalographic changes, particularly the presence of local spike discharges. A focal slow wave which is noted at rest following a seizure may also be helpful in identifying a focus, but such slow activity may raise the ominous possibility of a neoplasm and may require additional work-up beyond the standard pneumoencephalogram. Among the clinical aspects which strongly indicate a focal origin for a seizure are not only focal twitches, but also numbness or palsy of a limb in the immediate period after a seizure.

In addition to location of foci, the clinician must be certain that the patient is a good surgical risk. In general, young individuals are better candidates, though surgery may be indicated in as many young adults as in children. If the social situation is completely abysmal, if motivation for cure is nil, and if major psychiatric problems are a prominent feature of the case, prolonged thought and discussion among the subspecialties involved is mandatory before undertaking surgical therapy. While it is true that sometimes psychiatric disorders or behavioral disturbances are ameliorated by the relief of seizure discharges, it has not been our primary effort to operate for psychiatric reasons and much "psychosurgery" is doomed to failure. It is always much more difficult to be certain of what benefit has been accomplished in cases with primary psychiatric problems and infrequent seizure disturbances, and selection from these cases is fraught with hazard.

In summary, then, we feel that our selection of epileptic cases for surgery has been good since the results appear to have been excellent up to this point. Patients should not be selected solely because of inappropriate pressure from family or

personal physician that "something has to be done." The neurologist and neurosurgeon should use time to indicate the characteristics of the seizure disorder; and a single evaluation is inadequate.

Review of the Literature

Leaders in the field of cortical excision have included Rasmussen,² Penfield,³ Baldwin,¹ and the English neurosurgeons, such as Falconer.^{3,4} The latter group has concentrated on excision of the anterior temporal lobes.⁵ Many individual neurosurgeons have excised portions of the temporal lobe in patients with intractable temporal lobe discharges hoping to relieve seizures and behavioral disturbances. It is intriguing that over 50 percent of the cases reported from England have had definite pathologic abnormalities found when serial sections of the tissue from the temporal lobe were examined, even though no overt pathologic process was suspected prior to surgery. There is still dispute in the literature as to whether the gliosis and cortical scarring is secondary to birth or other trauma.

In unpublished data, Rasmussen has reported almost 100 cases from the Montreal Neurological Institute, with excellent results in from 60 to 70 percent. Late complications following surgery have been particularly prominent in patients with major hemispherectomies, and these complications particularly include bleeding into the cavity left at surgery. Because of this complication and the lack of great benefit from wider excision, hemispherectomies are probably less desirable than a partial removal of the scarred cortex in these children. Most of our patients have had much smaller scars than the children with infantile spastic hemiplegia in whom hemispherectomy would be considered.

electroencephalogram unquestionably gives additional data as to the locus of maximal irritability. Scar tissue has not been considered electrically active itself; but scar tissue may mechanically distort surrounding tissues, change the local blood flow, or isolate cortical tissue to the extent that seizure activity explodes in tissue near the scar.

There are numerous surgical procedures in addition to cortical excision which have been undertaken, particularly overseas. These include excision or destruction of the amygdaloid nucleus, section of the corpus callosum, or undermining of cortical tissue without actual removal of the cortex itself. It is our opinion that most of these procedures are lacking in clinical evaluation at this time and are less reasonable than direct excision of an area of cortex that is obviously electrically irritable, particularly when such an area is close to or involved in the scar tissue.

There has accumulated in the last 20 years more extensive literature on the electrical aspects of this subject than on the surgical features. The entire concept of the electrical "focus" has become controversial, for example, since discharges in cortical areas often are linked to abnormalities in subcortical regions. The electrical aspects of temporal lobe discharges, which can originate outside the lobe, has prompted some observers to question that electrocortography is even required before excision of the anterior portions of the temporal lobe. These details are well reviewed by Marsan.6

Conclusion

It is our opinion that cortical excision for seizure control provides a useful therapeutic measure in a small number of carefully selected patients as in the several dozen reported here. We review four cases done in the past two years. Patients in whom surgery is indicated will represent less than 1 percent of the seizure population which attends any clinic, though the procedure should be considered more frequently than this. Cortical excision for epilepsy is a time-consuming, difficult activity which involves numerous professionals, but it can give great rewards in carefully selected individual patients.

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Some Unresolved Questions Regarding Emergency Department Physicians

Oscar P. Hampton, Jr., M.D.

A personal evaluation of problems and conditions involving patient-care delivery systems in hospital emergency rooms or departments.

PHYSICIAN STAFFING of hospital emergency departments (EDs) formerly was no problem. Recently and for many reasons, however, it has become quite a complex problem.

For optimal ED treatment of all critically ill or injured, certainly the physicians on duty among them must possess broad knowledge and skills. These include:

- 1. Restoration and/or maintenance of a patent airway, including skills for orotracheal and nasotracheal intubation.
- 2. Cardiopulmonary resuscitation (CPR)—mouth-to-mouth artificial ventilation and external cardiac compression some now require demonstrated CPR capability on a Resusci-Anne doll for annual reappointment to the medical staff; electrocardiograph interpretation; external elec-

trical defibrillation; the use of antiarrhythmic drugs; and resuscitation from cardiac shock.

- 3. Thoracostomy for hemopneumothorax.
- 4. Pericardial aspiration for cardiac tamponade.
- 5. Control of external hemorrhage and resuscitation from hemorrhagic shock.
- 6. Evaluation of intracranial and spinal cord injuries.
- 7. Initial therapy of burns and resuscitation from burn shock.
- 8. Tetanus prophylaxis in wound management.
- 9. Diagnosis and initial management of non-traumatic surgical and medical emergencies in adults, children, infants, and neonates.
- 10. Poisonings, drug overdose and toxicity, and acute psychiatric problems and their management.

Others, including obstetric and gynecologic emergencies, could be added. Additional necessary knowledge and skills are placement of intravenous catheters for continuous intravenous fluid administration and for central venous pressure monitoring; indications for and therapy based upon blood gas determinations; diagnosis and treatment of acidosis and alkalosis — both metabolic and respiratory; and fluid and blood electrolyte needs and balances.

A single physician is unlikely to possess all of the identified knowledge and skills in depth. Fortunately, only a minority of ED patients require them. The majority require only the capabilities of a good family physician. Even so, one or more of the list of knowledge and skills may be crucial at any time for a critically ill or injured patient.

Currently, those staffing EDs may be grouped into five categories: (1) residents (interns herein

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are considered first-year residents); (2) on-call medical staff rosters; (3) the Pontiac Plan some medical staff members voluntarily staff the ED on four-to-eight-hour shifts on a fee-for-service basis; (4) physicians including "moonlighting" residents under contract individually with hospitals; and (5) physician groups under contract for full-time coverage. Each category offers advantages and disadvantages which vary with the hospital needs. A category used by hospital A may be totally impracticable for hospital B. In fact, none of the five categories is the ideal, which would be 24-hour coverage with certified specialists in each specialty concerned with injuries, diseases, and conditions, emergent or otherwise, that bring patients to an ED — an impracticable concept.

The advantages, disadvantages, capabilities, and availability of each category of ED physicians vary considerably.

Residents

For optimal staffing, a senior resident in at least the third postdoctoral year in each major specialty (general surgery, internal medicine, obstetrics and gynecology, and pediatrics - or access to a nearby children's hospital) must be on duty in the ED at all hours and be assisted by junior residents. Senior residents in the surgical specialties must be in the hospital on call to the ED. First-postdoctoral-year residents (formerly called interns) unsupervised by senior residents are inadequate as ED physicians.

Such staffing is the most advantageous of the five categories. Collectively, a corps of senior residents may be expected to possess more of the identified broad spectrum of knowledge and skills than any other category. Senior residents tend to act promptly, decisively, and effectively. Moreover, staff specialists are available to them promptly for consultation or assistance.

When residents merely remain in the hospital at all times available to be called to the ED, the capabilities of the ED physician may be good, but their availability is less than optimal for patients with life-threatening conditions. The system is adequate only for the run-of-the-mill quasiemergent patients.

ED physicians comprising the remaining four categories are less likely individually, or even collectively, among those on duty at one time to possess each of the identified knowledge and skills covering multiple specialty fields. For low-severity emergent and nonemergent patients, their expertise is more likely to be adequate.

Medical Staff Members On Call

This category, used by about two thirds of the 5,746 nonfederal, short-term, general hospitals in the United States, according to 1971 American

Hospital Association (AHA) data, doesn't call for a physician in the ED at all hours. Moreover, many hospitals using this category usually do not even keep a physician in hospital at all hours, a glaring deficiency. For patients with life-threatening conditions, this ED staffing plan is the poorest. Availability as well as expertise is a crucial ingredient.

Medical Staff Members Under the Pontiac Plan

This category offers availability. A physician should be on the spot for bona fide emergencies. However, the physician on duty may not have the particular expertise needed and may have to call in the appropriate specialist, so optimal treatment may be delayed. Actually, this plan is designed principally for low-severity emergent and nonemergent patients. As a rule, only one physician is on duty in the ED at any one time, a distinct potential disadvantage.

Contract Physicians Including "Moonlighting" Residents

This category usually is used only for specific shifts known to have significant caseloads and seldom for daily round-the-clock staffing. It offers only availability, particularly at rush hours, but usually only that of a single physician. He is unlikely to possess all of the desired knowledge and skills for all truly emergent conditions.

This category carries other disadvantages. Contract physicians often are not medical staff members and, therefore, are responsible only to the hospital administrator. They usually are paid a fixed salary which the hospital often expects to recover by collecting professional service fees. Some administrators may hope to make a "profit." The system borders on the hospital practice of medicine.

Full-Time Groups

A significant number of hospitals, principally those without a full complement of residents in the major specialists, have adopted this ED staffing plan. AHA data indicate 425 to 450 full-time groups are in ED practice at this time, but this estimate may be high. Groups now furnishing round-the-clock staffing of EDs provide services principally for low-severity emergent and nonemergent patients but also to a few seriously ill or injured. Some have become reasonably proficient in many of the areas identified previously as necessary for optimal care of truly emergent patients.

Many administrators, anxious to improve ED services, as a response to criticism about long delays in the ED, in an effort to avoid litigation involving the hospital and, perhaps in a few instances because of a profit motive, have jumped

at the opportunity to staff their EDs around the clock with licensed physicians and have employed physician groups to staff their EDs.

Medical staff physicians usually like the system. They are relieved of either a regular tour of duty in the ED or of nuisance calls from the ED nurse. Moreover, if the patient's condition "amounts to something," the ED physicians usually provide the patient with some relief and call in a medical staff specialist or otherwise make the indicated referral.

Not all medical staff physicians, however, are pleased with the system. Reports indicate that some ED physicians, particularly those on a feefor-service basis, persistently fail to call staff physicians even when requested to do so by the patient. They treat the patients themselves and merely instruct them to contact their own physicians for aftercare. Also, some practicing physicians have complained about the incompetency of some ED physicians. A surgeon in a Western state recently reported that one ED physician merely stuck an open 16-guage needle into a pleural cavity, ostensibly to correct a clinically diagnosed pneumothorax. If the diagnosis was not correct before, it certainly was afterward!

There is concern, therefore, about the capabilities for effective care of the critically ill or injured patients of many rank-and-file physicians in full-time groups and of many contract ED physicians. The overwhelming majority are "second career." Most have come from general practices, a field where the necessary knowledge and skills probably have not been maintained. These physicians, and also specialty physicians who have entered this localized field of practice, require an abundance of continuing education in the identified areas. Hospital administrators and trustees who have contracted with physician groups or individual physicians for ED staffing are subject to criticism and possible legal action unless they insure their broad capabilities.

Currently, a number of hospital residencies in so-called "Emergency Medicine" are in being for "first-career," ED physicians. Essentials for such residencies have not been finalized. It remains uncertain whether the current residencies for prospective ED physicians will equip them with the necessary knowledge and skills for life-saving, emergency medical care. They should equip them for the initial treatment of low-severity, emergent and nonemergent conditions which largely comprise the ED caseloads of hospitals currently employing ED physicians.

However, the system has proved itself and is here to stay. The only deterrents to the growth of ED staffing by full-time groups appear to be (1) a real economic depression, which could lead medical staff practicing physicians to staff the ED themselves as one means of professional income; and (2) realistic categorization of hospital emergency service capabilities resulting in the closing of many hospital EDs because they are no longer needed by the community. Categorization would minimize the need for all categories of ED physicians except residents.

American College of Emergency Physicians

The subject assigned to me mandates some comments regarding the American College of Emergency Physicians (ACEP) which was formed in September 1968. It now has between 4,500 and 5,000 members but it appears that only about half, if that many, are full-time ED physicians.

In varying ways, ACEP has gained recognition by some medical organizations including the AMA Council on Medical Education. It recently received accolades in an article in Medical World News

ACEP has supplied some of the continuing education needed by many of its members. Its Journal has carried many excellent articles by well-known specialists on various facets of emergency medical care in an ED. Programs at regular or specially arranged ACEP meetings have included patient-care lectures by guests who are recognized specialists. Recent printed programs, however, indicate a predominance of member-lecturers. Perhaps ACEP has decided that its members now are capable of providing continuing education for their own.

Despite ACEP's success to date, questions have been asked about its tactics directed at specialty recognition deserving of an American Specialty Board. When it was founded, the organization was given the prestigious title of a College despite requirements for membership of only a license to practice, a \$10.00 fee, and an expressed "interest" in emergency medicine. An "American Association" would have been more appropriate. By tradition, medical specialty groups organizing themselves into colleges have had as founding members physicians already recognized by their peers as specialists possessing in-depth knowledge and skills in their respective fields, far more than other practitioners. Moreover, why didn't the title show "of Emergency Department (or Room) Physicians" to connote the professional activities of the individuals who formed ACEP and of many prospective members?

Several founders, asked about the minimal membership requirements, replied that a large number of members were needed regardless of any tangible involvement with emergency departments. The leader in organizing ACEP, when asked if he would enroll every dues-paying member of the AMA, replied "I certainly would." These statements indicate a desire for numbers sufficient

to provide "medicopolitical influence," perhaps influence designed to gain specialty recognition.

Several reasons explain ACEP success in membership enrollment. Physicians practicing fulltime in EDs would be expected to join. At its founding, ACEP overtly advocated a certifying "American Board of Emergency Medicine," which must have been exceedingly attractive to potential members who possess neither a College nor an American Specialty Board certificate. Established American Colleges have rigid requirements for prospective members and do not overtly seek them. Rather, physicians seek College membership and many applicants are rejected. One wonders if ACEP has rejected a single applicant.

In my opinion, treatment of patients in an ED is not the practice of a medical specialty and physicians practicing full-time in this locale are not medical specialists. The activities of these physicians borrow from every field of medicine internal medicine, surgery and the surgical specialties, pediatrics, obstetrics, gynecology, and psychiatry—as well as from subspecialties of these recognized specialty fields. If a physician practicing full-time in an ED were to be considered a specialist, would it not follow that physicians practicing full-time in large clinics are specialists in "clinic medicine," and those in the armed forces are specialists in military medicine.?

Recognition as a medical specialty has come from in-depth knowledge and skills in a specific, well-defined field (not locale) of clinical practice. Full-time ED physicians require only the knowledge and skills essential to the initial care of a single episode, emergent or more likely nonemergent, of the diseases and injuries routinely treated, at least in the initial phase, by general practitioners. A field of clinical practice that cuts horizontally across all specialty practice fields is not a true medical specialty. ED physicians are firstcontact or primary physicians. They do not render secondary or tertiary medical care as indentified in the Millis Commission Report.

As full-time ED service is not the practice of a medical specialty, an American Board of Emergency Department Medicine, or particularly of mere "Emergency Medicine," should not be established. One can envision a physician certified by an "American Board of Emergency Medicine" contending that he is qualified to render inhospital emergency medical care and is qualified to operate on an emergent surgical patient, particularly if he is working in an ED of a hospital with only a few qualified staff surgeons who cannot be located on a single (perhaps half-hearted) effort. This possibility was brought home recently when an ACEP member, who advocates that emergency medicine is a specialty which should have a certifying board, made a statement to the effect that emergency physicians are not to be confined to the emergency department; they are to go into the hospital from time to time to treat emergent in-hospital patients.

Full-time ED physicians could achieve special recognition within the American specialty board system without a specialty board. A Certificate of Special Competence could be established by the American Board of Family Practice. First-career ED physicians would first complete a residency in Family Practice and then have one to two years of graduate education in ED Medicine. They would qualify for certification by the American Board of Family Practice and for its Certificate of Special Competence in ED Medicine. Those in second careers, already certified by the American Board of Family Practice, might be made eligible to receive it under special arrangements.

Last July, the AMA Council on Medical Education, concerned about established residency programs in "Emergency Medicine," held a conference cosponsored by ACEP titled "Education of the Physician in Emergency Medical Care." Excluding AMA staff, at least half and probably two thirds of the participants were ACEP members.

Literature for four workshops, largely ACEPdeveloped, included ACEP "Essentials of a Residency Program in Emergency Medicine" as the basis for the workshop, "The Education of the First Career Emergecy Physician." Eleven of 15 in this workshop were ACEP members. The "straw-man" essentials stated that the entire teaching faculty of an approved residency must consist of "specialists in emergency medicine," not surgeons, pediatricians, cardiologists, internists, or other specialists. The conference was a forum for advocacy and not for earnest deliberation of subjects concerning many national specialty societies and boards. Major issues appeared decided in advance.

Another conference is indicated to consider unresolved problems concerning full-time emergency department physicians, both first- and second-career. The conferees should be an equal number representing each established American Specialty Board and National Specialty Society concerned with ED staffing problems and services. Of course, ACEP should have representatives to present its viewpoints. It is hoped that some group or groups will arrange such a conference rather soon.

A New Acne Cleanser

K. William Kitzmiller, M.D.

A new abradant cleanser using water-soluble sodium tetraborate decahydrate particles is described, and the results in the study of 59 patients presented. In this group of patients, this product proved to be an extremely effective means of cleansing the skin and treating the comedones of acne.

there are two important, but most probably the least-appreciated, measures for the patient to follow. First, leave the lesion alone; that is, do not pick, squeeze, or scratch it. Second, keep the skin of the involved areas meticulously clean. Our study involved the evaluation of a new material that will be a welcome addition to the armamentarium

A CNE HAS LONG BEEN THE BANE of the adolescent's existence. Topical therapy has been practiced since antiquity, as this disease was recognized by the Greeks and Egyptians. In fact, Cassius, in 100 A.D., wondered "why acne should occur in the prime of the youth and strength" and he came to the conclusion that "the nobilest and best elaborated nutrient fluids stagnate and accumulate in the regions affected." It is one of the most common problems handled by dermatologists. Some studies indicate that acne affects as high as 90 percent of the adolescent population. Various classifications of acne have been set forth. The one that appeals to me is that of Reisner³ in which he describes two types of acne:

1. Noninflammatory acne consisting of closed and open comedones which are compact masses of keratin, sebum, and bacteria that dilate and occlude the follicular duct.

2. Inflammatory acne consisting of papules, pustules, and cvsts.

We like to consider the primary lesion of inflammatory acne as a comedo associated with rupture of the pilosebaceous apparatus. This is known in the vernacular as a "zit."

The study of the treatment of acne is almost as old as the disease itself. In the treatment of acne vulgaris,



Fig. 1. Typical example of polyethylene particles used in a popular abradant.



Fig. 2. Typical example of aluminum oxide particles used in another abradant cleanser.

Presented at the 17th Annual Meeting of the Noah Worcester Dermatological Society, Marco Island, Florida, March 3-9, 1974.

Dr. Kitzmiller, Cincinnati, Assistant Clinical Professor, Department of Dermatology, University of Cincinnati College of Medicine.

Reprint requests to 8040 Reading Road, Cincinnati, Ohio 45237

Submitted September 30, 1974.



Fig. 3. Example of particles used in this new product. Sodium tetraborate decahydrate particles are seen to possess a uniform smooth-edged appearance in contrast to particles shown in Figs. 1 and 2.

of the dermatologists, particularly as an aid to the patient in achieving cleanliness and the removal of the closed and open comedones. It is of particular use in the noninflammatory type of acne.

Materials and Methods

Abradant cleansers have been used for many years and offer a unique aid in controlling excess sebum and preventing comedone development. These cleansers, until now, contained finely divided particles which are nondissolving, such as polyethylene and aluminum oxide. Now there is a cleanser that contains dissolving abradant particles (sodium tetraborate decahydrate). It has been shown that the dissolving particles possess certain advantages to the user. Therefore, a new dissolving abradant cleanser has been introduced. The product incorporates the sodium tetraborate decahydrate particles (ScrubulesTM) in a combination of surface-active, soapless cleansers. The polyethylene and aluminum oxide particles are rather undesirable because of the irregularity of the size, shape, and sometimes-sharp edges (as shown in Figures 1 and 2) and the difficulty of the removal of the insoluble particles which is often tedious. Also, one of the main problems of the earlier abradant cleansers has been the so-called "beefsteak face" resulting from excessive rubbing with the insoluble particles. The particles in the cleanser we used were sodium tetraborate decahydrate.* (See Figure 3.) These particles have been found to possess a uniform smooth-edged appearance as compared with other particles, and since these particles dissolve while in use, they overcome the principle objections of previously existing cleansers. By adding water freely during its use, one can completely dissolve the particles within a minute



Fig. 4. Scanning electron microphotograph (SEM) of soap-and-water scrub of cheek before treatment showing: (A) stratum corneum with no major leveling or smoothing; (B) desquamating epithelial tissue; (C) two plugged hair follicles; and (D) facial hair artifact.

after application. This prevents excessive scrubbing which can result in irritation and serves as a self-limiting guide for the patient during the use of the cleanser. In our study, 59 patients were selected at random from a suburban dermatologist's office practice. These patients all had clinically diagnosed acne vulgaris of varying degree and severity while under therapy prior to the study. There were 22 males and 37 females, ranging in age from 12 to 18 years. Forty patients were in the noninflammatory group, and 19 patients were classified as inflammatorytype acne. Previous therapy had included various keratolytic soaps, drying topical medications, and antibiotics. The patients in this study were given the abradant cleanser and advised to use it twice daily along with a bland, tinted acne lotion. In as many instances as possible, antibiotics were discontinued in an attempt to get a true



Fig. 5. SEM of skin prior to washing with soap and water showing (A) stratum corneum with no major leveling or smoothing; (B) desquamating epithelial tissue; (C) two plugged hair follicles; and (D) facial hair artifact.

^{*}The material used in this evaluation is known as Komex® (sodium tetraborate decahydrate), manufactured and supplied by Barnes-Hind Pharmaceuticals, Inc., Sunnyvale, California.



Fig. 6. Oily skin before treatment with nondissolving abradant cleanser showing (A) roughened stratum corneum with crevices; (B) desquamating epithelial tissue; (C) plugged hair follicle; and (D) facial hair artifacts.

picture of the efficacy of the cleanser. The patients were given enough cleanser to use twice daily for a period of a month and then were seen at the end of the month for evaluation. At the follow-up visit, a questionnaire was completed.

Comments

Favorable comments concerning the material inlude:

1. Ninety-five percent of the patients felt that the abradant skin cleanser left the skin smooth and soft (Figs. 4-9)

2. Seventy-six percent of the patients reported no irritation. Twenty-four percent of the patients reported

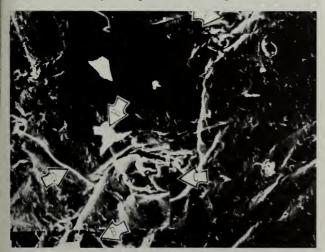


Fig. 8. Oily skin before treatment with dissolving abradant cleanser showing (A) roughened stratum corneum with crevices; (B) desquamating epithelial tissue; (C) plugged hair follicle; and (D) facial hair artifact.



Fig. 7. Skin after 60-second scrub with nondissolving abradant cleanser. Note (A) moderate smoothing of stratum corneum; (B) some removal of desquamating epithelial tissue; (C) moderate cleansing of hair follicle and loosening of the plug; and (D) facial hair artifact.

some form of irritation related to use of the product, such as redness, tight feeling, slight burning, transient dryness, and stinging. These reactions may be desirable. (Generally, when a patient is treating a condition such as acne there may be an overawareness on the patient's part initially that may reflect in the observations recorded here. A certain small percentage of patients will experience idiosyncratic responses to products, such as those with fair skin.)

3. Seventy percent felt that the abradant action was appropriate for their problem. Thirty percent of the patients felt that the abradant action was "too much," but follow-up instructions regarding proper use of the product, such as using more water to dissolve the particles, reduced this phenomenon.

4. Sixty-six percent stated that the abradant particles

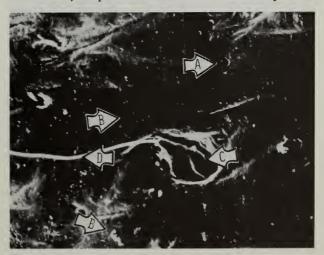


Fig. 9. Oily skin after 60-second scrub with dissolving abradant cleanser. Note (A) marked smoothing of stratum corneum; (B) near-complete removal of desquamating epithelial tissue; (C) hair follicle well cleansed with core loosened; and (D) facial hair artifact.

in our cleanser were "just right" as compared to other materials they had used previously.

5. Thirty-six percent of the patients reported that their facial skin remained oil free from one to three hours, 46 percent reported that their skin remained oil free from four to six hours, and 17 percent felt that their skin remained oil free for eight hours.

6. The majority of the patients felt that the material was easy to use and the dissolving feature made it particularly easy to remove. It was found that if more water is added during the cleansing process, this will hasten the dissolving of the granules and eliminate most of the adverse reactions.

7. The product appeared to perform well as shampoo. In our study, the patient acceptance of the material and the resultant diligent use of it was certainly better than 80 percent. On their return, many of the patients expressed marked interest in being able to continue the cleanser because of its ease of use and effectiveness.

Adverse comments included: facial redness 15 or 20 minutes after use, occasional flaring of pustular acne, and excessive drying.

The author observed the material to be particularly effective in the removal of comedones. It was relatively free of side effects; no evidence of undue irritation or

sensitization was found. The material appears to be an extremely effective and acceptable degreasing agent. Particle solubility with disappearance of the fragments served as an end point of therapy for the patient. In the majority of the cases, this gave the user a sense of accomplishment in his treatment.

Summary

A new abradant cleanser utilizing water-soluble sodium tetraborate decahydrate particles has been described, and the results in the study of 59 patients has been presented. In this group of patients, this product proved to be an extremely effective means of cleansing the skin and treating the comedones of acne. It should prove to be a definite adjunct to the dermatologists' armamentarium in the management of acne.

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President's Address

James L. Henry, M.D.

Presented before the House of Delegates of the Ohio State Medical Association on Sunday, May 11 in Columbus.

Being the President of the Ohio State Medical Association is a rare privilege. Indeed, it is an even greater honor. I thank you for both.

This Association could best be served if each member had the opportunity to have the executive responsibility for a year. This opportunity demonstrates the multitude of problems, opinions and decisions one must encounter. It is safe to say that many pre-determined viewpoints and ironclad opinions would be less assured, and by chance even altered.

As President, one must serve to the best of his ability and with full knowledge of his responsibility to all of the members of this Association. Such a course is not easy. Diametrically opposed opinions, positions, interpretations and modalities are very prevalent in this Association, just as in our society generally today. Bulls are gored, and it is not always true that what's good for the goose, must be good for the gander.

The President and officers and the Council of O.S.M.A. are constantly being confronted by demanding decisions and pressures. These require an ongoing, imperative educational program to ensure survival, viability and equilibrium for this organization and occasionally for self.

One has the opportunity to learn that black is not always black; nor is white always white. Council has been made acutely aware of man's inhumanity to man, and faced squarely the issue of Laetrile.

Many sessions of Council have been spent determining with legal counsel the interpretation of the meaning and intent of the Constitution and Bylaws. We have all experienced many opportunities to learn the worth and wisdom of practical politics, both medical and legislative.

In wrestling with the difficult and demanding problem of professional liability, or a dirty word—malpractice, the lessons learned about politics have been invaluable. The effectiveness of this learning is being put to the supreme test in dealing with legislative issues, interprofessional relationships and serving the membership's best interests in the malpractice situation.

The officers, Council and a very dedicated staff are sincerely determined to serve all of the membership of OSMA. The operating motto seems to be "to satisfy all of the members all of the time." This is a truly admirable and responsible approach to stewardship. However, we have not followed all of Mr. Abraham Lincoln's advice on the matter. He went on to point out "but you can't please all of the people all of the time."

But, please, let the record show that for the past year we have tried like hell. Your officers, Council and staff have worked hard to create a more unified, stable service-oriented state medical society which serves better and more effectively represents the membership. By any set of criteria, standards and norms, the past year has been more active than ordinary—in problems, progress and response.

It is proper for this House of Delegates to have an update on events and actions mandated by the 1974 House of Delegates.

In July, 1974, OSMA moved into its headquarters' building at 600 South High Street. This is a first! Never before has OSMA been a property owner—always a renter or a space moocher, but never an owner. Now, we are in the main stream of our society, a freeholder with a mortgage. Tomorrow, there will be an Open House and I invite each of you to inspect the facilities and services available to you.

President's Address/continued

The mortgage is \$190,664.45. This is held by the Employees Pension Trust Fund. Payments of \$29,119.20 are made to this fund annually. This is a pay-to-yourself arrangement with two results: the employees benefit and necessary office space insures that OSMA membership can best be served.

Field Service

Many of the membership have met Mr. Robert Holcomb at county medical society meetings. Through this field service mechanism, the services available to the OSMA members are brought to the "grass-roots." Constitution and Bylaws are updated. Membership billing is coordinated. Policy questions are answered. Through this service, the OSMA membership is better informed and better served. Mr. Holcomb has been joined by Doug Freeman of Dayton. Doug is a son of the late Bob Freeman, a most knowledgeable and revered executive secretary for the Montgomery County Medical Society. Expect more and demand more from the Field Service Department. Holcomb et al are your direct link to OSMA.

Public Relations

House of Delegates Amended Resolution No. 6-74 mandated an enlarged, activist public education program to demonstrate the effectiveness of the present system of medical care delivery. At the same time, the program exposes the deleterious effects of a government supervised health program such as exemplified by P.L. 92-603.

The Public Relations Committee, most capably chaired by Luther High, M.D., has developed an ambitious and encompassing public relations program. The program relates to all media and to physicians. Physicians' offices will be utilized for the patient's education. Awards will be given for the best reporting.

To accomplish this vital program, an expansion of the public relations department was essential. The Division of Media Relations has been established within the Public Relations Department. This division is headed by Ms. Rebecca Doll. She has the responsibility for preparation of material for distribution to the media, the membership and the public at large.

Please note that a time when the AMA has found it necessary to curtail its service activities, OSMA has felt the importance of providing all possible services to its members. At no time in history have physicians needed more service to deliver excellent health care. Your needs are recognized and are being served by OSMA.

State Legislation

In response to House of Delegates Resolution 5-74, a full-time department of state legislation has been developed and staffed. Mr. Dave Rader is the able director. His associate is Mr. Brent Mulgrew, a newly "ordained" lawyer.

These gentlemen are working long and hard with the Legislature and other professional associations to develop legislation that fulfills the dictates of this House. They have developed a revision of the Medical Practice Act which has been used in solution of the malpractice problem.

H.B. 682 is the product of the consortium of interests involved in professional liability. The Legislative Department has had almost endless input into the development and course of this bill. Continuing improvements are being developed to assure that this bill, H.B. 682, provides adequate insurance at a reasonable cost for physicians and facilities in this state.

The establishment of the Legislative Department has provided an opportunity to reassign other staff men to the important functions of committee responsibility, thereby, improving the quality of service in both areas.

The committees dealing with Government Medical Care Program, and the several kindred organizations, such as Medical Advances Institute, Ohio Medical Indemnity, Inc., and the Ohio Foundation for Medical Care, have had increased staff support by the return of Herbert Gillen from MAI. A closer and more effective liaison has been established. In this way, the OSMA input can be more direct, more meaningful and implementation of OSMA Council policies with the Welfare Department, Health Department, et al, can be more productive.

Commission on Medical Education

The voluntary Physician Recognition/Continuing Medical Education Program directed by this House of Delegates after in-depth study by the Commission on Medical Education was implemented January 1. Judging by the response to the special section in the December issue of The Ohio State Medical Journal, I am happy to report that:

Number one: A significant number of members has indicated interest in qualifying for the award.

Number two: A significant number of hospitals and other continuing medical education facilities has taken steps to achieve accreditation for our program.

I invite you to visit the Continuing Medical Education exhibit at the Veterans Memorial Auditorium for more information about this program.

Peer Review

Amended Resolution No. 23-74, "Peer Review", has created many problems for the officers and Council of OSMA. Like beauty is in the eyes of the beholder, so is this resolution. Interpretation of the wording and intent of this resolution could be called controversial at best. A lengthly and detailed opinion submitted by OSMA legal counsel, upon request of the President of OSMA, has not appreciably reduced the controversy.

The controversy has been heightened by the formation of several peer review (PSRO) organizations and a support service organization in this state. This ongoing debate has become extremely divisive and disruptive. Several resolutions to be considered by this House of Delegates are direct actions and reactions to this issue.

A unified organization—this Association—is a must to assure effective negotiations with the government on behalf of local physician organizations. Already there is apparent evidence that the federal government is enjoying the benefits of fragmentation, which has been achieved by dollars and regulations. A solid unit with a singular purpose and direction is vital.

In order to clarify the intent of the House of Delegates and the membership that it represents, the OSMA Council has submitted a direct resolution. Its rejection or acceptance will surely and unequivocally direct the Council, officers and membership of this Association.

Enormous attention and time have been devoted to this resolution by the officers and Council in an attempt to fairly and objectively interpret Resolution No. 23-74 and thus establish accurately the official position.

This House must determine the official position of this Association relative to PSRO and Peer Review, Clarification is absolutely necessary. Only in this manner can the leadership of OSMA follow the mandate of the membership.

"A unified OSMA is a must to assure effective negotiations with the government on behalf of local physician organizations. A solid unit with a singular purpose and direction is vital."

In 1904, the Charter of the Ohio State Medical Association stated that:

"The purpose for which said corporation is formed is: the purpose of this Association shall be to federate and bring into one compact organization the entire medical profesion of the State of Ohio, and to unite with similar associations in other States to form The American Medical Association, with a view to the extension of medical knowledge and to the advancement of medical science, to the elevation of the standard of medical education, and to the enactment and enforcement of just medical laws, to the promotion of friendly intercourse among physicians, and to the guarding and fostering of their material interests, and to the enlightenment and direction of public opinion in regard to the great problems of state medicine, so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life."

This purpose is both honorable and realistic. It also is as valid in 1975 as it was in 1904. In fact, perhaps it is more so. This House of Delegates must carefully and objectively consider resolutions that could affect the Charter of this corporation. Adoption of changes that could create a corporation incapable of meeting the Charter requirements would be most destructive and definitely not in the best interests of patients and physicians, who are the beneficiaries of the energies of a compact organization.

I urge that objective, unemotional deliberations be

employed by the reference committees and this House of Delegates in consideration of ALL resolutions.

Medical Malpractice

While decrying negative attempts to destroy the solid unity and compactness of the Ohio State Medical Association, and recognizing that fragmentation and isolation can well be the decline and fall of medicine. I am happy to report that the medical malpractice crisis has united physicians in this state as no other issue to my knowledge. There seems to be a singular support and direction in the efforts of OSMA to solve this onerous situation. Literally hundreds of letters and telephone calls have been received from the membership. Many of the workable, practical and presentable ideas have been incorporated in our negotiations with lawyers, insurance companies. other associations and the Insurance Department of the State of Ohio.

The opinions and suggestions for the most part have been sound and valid, and represent concerned evaluations of the problem. This Association, through special newsletters has attempted to keep you abreast of the developments. In addition, Mr. Jerry Campbell, of the staff, has worked very hard to make available insurance coverage for all members of this Association and indeed some non members. He has been ninety-nine and forty-four one-hundredths percent successful in making available coverage and, in most cases, at a rate less than originally quoted by insurance carriers. It is safe to say that, if indeed this issue of malpractice can be resolved to the satisfaction of the great majority of the membership, the Ohio State Medical Association will have fulfilled, in spades, its responsibility to each and every one of the

You have all received in the mail a summary of the official position of OSMA and an analysis of the legislative package that is being considered by the Ohio Legislature. All of us agree that each of the components of H.B. 682 may not be entirely satisfactory, but that it is an acceptable and responsible compromise. It can be improved upon in committee and will be. Out of this, indeed, come data so vitally needed and previously unaccessible to the physicians in Ohio. The Malpractice Commission concept, while very appealing to me and others, has severe drawbacks under Ohio law, not the least of which is the requirement that it must have a constitutional amendment to make it fly. Constitutional amendments are notoriously expensive, time-consuming and ill-fated. The decision to compromise on this point should be apparent.

I urge each of you to attend tomorrow afternoon's General Session on "Current Status of Professional Liabiilty Problems and Solutions," at which time the issues will be discussed in depth by experts in the field. You will have an opportunity to ask questions—questions that are of concern to you individually, or to members of your county medical society.

Thank you very much.

James L. Henry, M.D. President Ohio State Medical Association



Bioequivalence

New Council Members Elected By 1975 House Of Delegates



Maurice F. Lieber, M.D. President

Accepting the official gavel and President's Medallion, Maurice F. Lieber, M.D. became OSMA's new President during the House of Delegate's final session on May 14. He has served as President-Elect since last year's Annual Meeting in Cleveland.

Dr. Lieber delivered his first remarks as President to the House of Delegates, stressing OSMA's need for unity of purpose. He then introduced his wife, Doreen and two daughters, Diane and Jennifer, to the Delegates.

A Fellow of the American College of Surgeons, Dr. Lieber has practiced in his native city of Canton since 1947. A portion of his practice is in the field of industrial surgery with the Republic Steel Corporation and the Diebold Corporation. He was first elected to OSMA's Council in 1969 as Councilor of the Sixth District, a position he held for five years.

Dr. Lieber received his A.B. degree from Washington and Jefferson College and his M.D. degree from Johns Hopkins University School of Medicine. He continued at Johns Hopkins and Union Memorial Hospital in Baltimore for surgical training. He has served as President of the Aultman Hospital Medical Staff and as Chief of Surgery at Aultman. He is also on the Courtesy Staff of Timken Hospital, Canton, and the Molly Stark Hospital, Canton.



George N. Bates, M.D. President-Elect

Serving OSMA as President-Elect during the coming year will be George N. Bates, M.D. of Toledo. Dr. Bates was nominated by the Academy of Medicine of Toledo and Lucas County and elected by the House of Delegates

In assuming his new office, Dr. Bates relinquishes the position of Fourth District Councilor. C. Douglass Ford, M.D., also of Toledo, has assumed this position.

Dr. Bates is the Corporate Medical Director of Owens-Illinois, Inc., a worldwide firm employing 80,000. He is a diplomate of the National Board of Medical Examiners (1944), a Fellow of the American College of Surgeons (1950), Fellow of the International College of Surgeons (1954), and diplomate of the American Board of Surgery (1952).

During his tenure as Fourth District Councilor, Dr. Bates was Chairman of the Auditing and Appropriations Committee and the Council Fee Review Committee. He is an Alternate Delegate from OSMA to AMA.

Receiving his premedical degree from the University of Notre Dame, Dr. Bates continued his medical education at the Faculty of Medicine, McGill University, Montreal. He was awarded a M.D.-C.M. degree in 1942. Dr. Bates has served as secretary, vice-chief, and chief of the Medical Staff of St. Vincent Hospital.

New Council Members Elected



William Dorner, Jr., M.D. **Twelfth District Councilor**

Portage and Summit County Medical Societies became OSMA's new Twelfth Councilor District during the House of Delegate's Final Session on May 14. The two counties were previously within the Sixth District.

William Dorner, Jr., M.D., of Akron was appointed as the new district's Councilor by OSMA President, Maurice F. Lieber, M.D. Dr. Dorner will serve until the 1977 Annual Meeting when he will come up for election with Councilors of the other even-numbered OSMA Districts. His appointment was approved by OSMA's Council on May 15.

Dr. Dorner graduated from the Ohio State University College of Medicine. He studied Dermatology at the Graduate School of Medicine, University of Pennsylvania, Philadelphia. He is a Fellow of the American Board of Dermatology.

This year, Dr. Dorner assumed office as President of the Summit County Medical Society after serving as President-Elect in 1974. He was Chairman of OSMA's Section on Dermatology and is presently Chairman of the Medical Advances Institute's Dermatology Panel. From 1970 to 1974, he was a member of the Board of Directors of the Cleveland Dermatological Society.



C. Douglass Ford, M.D. **Fourth District Councilor**

C. Douglass Ford, M.D., has assumed office as OSMA's Fourth District Councilor. Dr. Ford replaces George N. Bates, M.D. who was named President-Elect by the 1975 House of Delegates.

Dr. Ford served as a delegate from Lucas County to the OSMA House of Delegates from 1969 through this year's annual meeting. He was a Councilor for the Academy of Medicine of Toledo and Lucas County from 1968 to 1970.

His premedical degree was granted by Wesleyan University in Middletown, Connecticut. He received his medical degree from New York Medical College in New York City. Dr. Ford took his residency in Internal Medicine at The Toledo Hospital, Toledo.

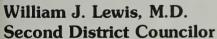
Dr. Ford was the Vice Chief of Staff at The Toledo Hospital from 1968 to 1972. He is currently a member of the hospital's medical staff and Director of its Radioisotope Laboratory. He also acts as a Clinical Associate at the Medical College of Toledo.

Since 1955, Dr. Ford has had a private practice in Internal Medicine in Toledo, He is a member of the Ohio Society of Internal Medicine.

From 1966 to 1968, he was President of the Northwestern Ohio Chapter of the American Heart Association.

By 1975 House Of Delegates





OSMA members in the Second District are represented by a new Councilor, William J. Lewis, Jr., M.D. A Family Practitioner in Dayton, Dr. Lewis is intensely involved in the activities of organized medicine.

Dr. Lewis is Immediate Past Chairman of the American Medical Political Action Committee (AMPAC), the second largest medical organization in the nation. Elected in 1973, his job was to see that AMPAC is an effective force in U.S. House of Representative races and U.S. Senate races.

Before being elected to AMPAC, Dr. Lewis was a member of the Board of Directors for Ohio Medical Political Action Committee (OMPAC). He served as Chairman of the Board for two years.

He is a past president of the Montgomery County Medical Society and an American Medical Association Delegate from OSMA.

A graduate of Indiana University's School of Medicine, Dr. Lewis is a Diplomate of the American Board of Family Practice. He is a member of the Ohio Academy of Family Practice and the American Academy of Family Practice.

As Second District Councilor, he will serve a two year term.



James Hutchinson Williams, M.D. Tenth District Councilor

An Assistant Dean of Ohio State University, James Hutchison Williams, M.D., is the new Councilor for OSMA's Tenth District. Dr. Williams is Assistant Dean for Student Affairs at Ohio State's College of Medicine, as well as a Professor in Obstetrics and Gynecology.

A member of the Academy of Medicine of Columbus and Franklin County since 1952, Dr. Williams has served as its President since January. Previously he was Secretary-Treasurer of the Academy.

He received his medical degree from Ohio State University in 1946. A Diplomate of the American Board of Obstetrics and Gynecology, he is engaged in the practice of obstetrics and gynecology. Dr. Williams is also a member of American Medical Colleges Group on Student Affairs.

In 1969, Dr. Williams was honored with the title "Man of the Year" by Ohio State's College of Medicine.

The Council's Other Members

James L. Henry, M.D., Grove City, Immediate Past President

William M. Wells, M.D., Newark, Secretary-Treasurer

Stephen P. Hogg, M.D., Cincinnati, First District

John Smithson, M.D., Findlay, Third District John J. Gaughan, M.D., Cleveland, Fifth District

C. Edward Pichette, M.D., Youngstown, Reelected from Sixth District

Robert E. Rinderknecht, M.D., Dover, Seventh District

Richard E. Hartle, M.D., Lancaster, Reelected from Eighth District

Thomas W. Morgan, M.D., Gallipolis, Ninth District

Robert G. Thomas, M.D., Elyria, Eleventh District





















Auxiliary Report

To The 1975 House of Delegates

"If two stand shoulder to shoulder against the Gods happy together, The Gods themselves are helpless against them, While they stand so."

And so, we, your wives stand shoulder to shoulder with you—and the Gods—and we hope the federal government will be helpless against us.

Those of you whose wives are actively involved in auxiliary know how dedicated we are to your profession. We are trying to build a rapport with our communities that you, the doctors, have not had time to build. First, I will tell you what we have done this year and then I will tell you what we could do.

We have 51 organized county auxiliaries with a state membership of 4,979 as of today. A membership team organized by our state membership chairman, Mrs. William Myers, visited all counties who were interested in this concept.

Auxiliary members were urged to contact their legislators concerning the Chiropractic licensing bill and the Osteopathic medical school bill. County auxiliaries, upon requests from their medical societies or academies, supported county mental health bills and endorsed issues for county health levies. At our Fall Workshop, a mini-Precinct Action Course was presented with the help of Mr. Rader and Mr. Mulgrew. On April 29, a special Legsline Alert was sent to county legislation chairmen to write immediately to their state senators and representatives to support H.B. 682, the Omnibus Malpractice Bill.

In response to a call from the Ohio State Medical Association, auxiliary representatives attended regional conferences sponsored by the Ohio Council of Churches on National Health Insurance. These representatives ably defended organized medicine's position. These regional conferences were the incentive for Cuyahoga County's Public Relations Seminar conducted by their academy's executive director. This seminar was designed to inform auxilians of issues and legislation concerning the medical profession as well as to inform auxilians how to answer



the critics of organized medicine.

One of my priorities this year was in the area of Health Education. My goal was to promote a total Health Education curriculum, K-12, to be taught by qualified teachers and health educators in every school system in Ohio. This goal will take many years to be realized but we have made a start. Under the leadership of Mrs. S. Baird Pfahl, State Health Education Chairman a pilot project was launched in her own county. Erie.

A mini-Health Education Conference was attended by auxiliary members as part of our Fall Workshop. Professionals from the State Department of Education, Ohio State University's Department of Health Education, and auxiliary members participated. At this time a progress report was given by Erie County on their pilot program. As part of this program, a Health Education Fair was held in the spring with 28 health related agencies displaying materials and programs available for educators, librarians and scout leaders who numbered 150 in attendance.

Cooperation between the Ohio State Medical Association and the auxiliary continued to improve. The state auxiliary president was invited to attend a meeting of the Council. This was a first! And I hope not the last! The staff of the association arranged a conference between representatives of the School Boards Association, the State Department of Health, the medical association and the auxiliary to discuss joint efforts for Immunization Month.

Cooperative efforts helped to make the auxiliary's Day at the Legislature a success. An orientation session at the beginning of the day and a "rap" session at the end were led by Mr. Rader, Director of OSMA's Department of Legislation.

Due to the efforts of Mr. Clinger, the medical association sponsored the auxiliary for membership in the State Planning Committee for Health Education in Ohio. This is an organization composed of representatives from official and voluntary health agencies, professional health

agencies and state universities that offer a health education major. All groups are involved in promoting health education programs and curricula in the schools. The auxiliary is the first total "grass roots" organization invited to join.

The staff of the association have been most generous with their advice, time and concern. They have never been impatient with us and have always been supportive of our efforts. Special thanks are due Mr. Page, Mr. Edgar, Mr. Clinger, Mr. Rader, Mrs. Dodson, Mrs. Tanner and Mrs. Wisse.

Our county auxiliaries have offered over \$26,000 for scholarships and loans in Health Career fields. They have contributed over \$61,000 to AMA-ERF with more to be added before the final collection date. Over 42,000 pounds of drugs, medical supplies and equipment were sent to World Medical Relief, Project Hope and Care-Medico. Thirty-two counties participated in Community Health projects. Included were: Blood Donor; Safety and VD programs; Worry Ins; Crisis Lines; Block Mother; Hearing and Vision screening; Talking Books and Friendly Visitor programs.

Family Health programs in which auxiliaries have participated are: Nutrition; Parenting; Sexuality, Child Abuse; Red Cross Lifesaving; Sickle Cell Anemia; Eye; Heart and Lung Disease. Several counties held workshops on Marriage and the Family. Many auxiliaries sponsor and participate in Mobile Meals programs. One county sponsored a Youth Ostomy Club. Several of our county auxiliaries have been recognized in the national auxiliary magazine, MD's Wife, for interesting and unique programs.

We have been busy this year as always.

I have told you what we have done this year, now I would like to tell you what we could do.

I see auxiliary members, in the future, encouraging two-way communication between the Ohio State Medical Association and its members,

I see auxiliary members encouraging reluctant doctor husbands to write letters to legislators and to get more involved in telling medicine's story to the public.

I see the members of the Ohio State Medical Association urging their wives to join the auxiliary in order to have a stronger, more unified force. We need their brains and arms and legs in our endeavors.

It is evident to me that if the profession does not hang together the doctors will hang separately.

Thank you for the opportunity to share our auxiliary year with you. Thank you for the space which you give us in *The Ohio State Medical Journal* to keep you and your wives informed of our activities.

Many thanks to Dr. Henry who has been marvelously cooperative and supportive of the auxiliary. Thanks to Dr. Smithson, our other advisor. Thank you all for your support

Most of all thank you for allowing us to share your profession.

Mrs. S. J. Glueck 1974-75 President, Woman's Auxiliary to the Ohio State Medical Association



Pro-Banthine® brand of propantheline bromide

Indications: Pro-Banthīne is effective as adjunctive therapy in the treatment of peptic ulcer. Dosage must be adjusted to the individual.

Contraindications: Glaucoma, obstructive disease of the gastrointestinal tract, obstructive uropathy, intestinal atony, toxic megacolon, hiatal hernia associated with reflux esophagitis, or unstable cardiovascular adjustment in acute hemorrhage.

Warnings: Patients with severe cardiac disease should be given this medication with caution. Fever and possibly heat stroke may occur due to anhidrosis.

Overdosage may cause a curare-like action, with loss of voluntary muscle control. For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted. Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthīne.

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Adverse Reactions: Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

Dosage and Administration: The recommended daily dosage for adult oral therapy is one 15-mg, tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

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Index to Actions on Resolutions

Report of Resolutions Committee No. 1 begins on page 495 Resolutions Committee No. 2, page 500 Resolutions Committee No. 3, page 505

Referred to

Resolut No	ion	Committee No			
	·		25	Catholic Hospital Association	No. 2
01	Professional Liability (Academy of Medicine of Columbus and Franklin County)	No. 1		(Academy of Medicine of Cleveland and Cuyahoga County)	
02	Professional Liability (Academy of Medicine of Cleveland and Cuyahog County)	No. 1	26	Abortion Advertising (Academy of Medicine of Cleveland and Cuyahoga County)	No. 2
03	Medical Malpractice Insurance (Holmes County Medical Society)	No. 1	27	Special Committee to Analyze Published Health Statistics for Dissemination to the Physician (Academy of Medicine of Cincinnati)	No. 2
04	Formation of a Professional Liabilities Review Commission for the State of Ohio (Alford C. Diller, M.D., Delegate, Van Wert Co.)	No. 1	28	Development of Outreach Program for Heart Disease and Stroke (Academy of Medicine of Cincinnati)	No. 2
05	Norms or Criteria of Medical Care (Academy of Medicine of Cleveland and Cuyahog County)	No. 1	29	Legislation to Protect Supply of a Life Saving Drug (Academy of Medicine of Cincinnati)	No. 2
06	HEW Regulations in Regard to Utilization Review Under the Social Security Act (Academy of Medicine of Cleveland and Cuyahog	No. 1	30	Earlier Detection of Breast Cancer (William J. Flynn, M.D., Member of Mahoning County Medical Society)	No. 2
07	County)		31	Information-Medical Advances Institute (Huron County Medical Society)	No. 2
07	Employ Non-Staff Physicians to do PSRO Utilization Review, Certification and Review (Academy of Medicine of Cleveland and Cuyahog	No. 1	32	Surveys (Huron County Medical Society)	No. 2
08	PSRO Information and Confidentiality (A)	No. 1	33	Minutes of OSMA Council Meetings (Huron County Medical Society)	No. 2
09	PSRO Information and Confidentiality (B)	No. 1	34	Itemizations — Costs and Services Rendered (Huron County Medical Society)	No. 2
10	(Academy of Medicine of Toledo and Lucas County PSRO Information and Confidentiality (C)	No. 1	35	Combined Annual Dues and Assessments (Geauga County Medical Society)	No. 3
11	PSRO Information and Confidentiality (D)	No. 1	36	Semi-Annual Meeting of OSMA House of Delegates (Stark County Medical Society)	No. 3
12	(Academy of Medicine of Toledo and Lucas County PSRO Information and Confidentiality (E) (Academy of Medicine of Toledo and Lucas County	No. 1	37	Election of Councilors to OSMA (Huron County Medical Society)	No. 3
13	PSRO Information and Confidentiality (F) (Academy of Medicine of Toledo and Lucas County	No. 1	38	Election of District Councilors (Mahoning County Medical Society)	No. 3
14	Exploitation of Physicians (Ross County Medical Society)	No. 1	39	Election of OSMA Councilors (Stark County Medical Society)	No. 3
15	OSMA Council Action on PSRO (Huron County Medical Society)	No. 1	40	Creating a Twelfth Councilor District (Summit County Medical Society)	No. 3
16	To Let Hospitals Implement PSRO (Huron County Medical Society)	No. 1	41	Appointment of Members to Resolutions Committee (Council of the Mahoning County Medical Society)	No. 3
17	OSMA Position on PSRO (Council of the OSMA)	No. 1	42	Voluntary Membership in OSMA (Council of the Mahoning County Medical Society)	No. 3
18	Confidentiality (C. G. Madsen, Jr., M.D. Member, Lake County	No. 1	43	Student Membership (Council of the OSMA)	No. 3
19	Medical Society) Region Six Peer Review Corporation of Akron	No. 1	44	Fiscal Notes (Council of the OSMA)	No. 3
20	(Council of the Mahoning County Medical Society Reaffirmation of OSMA Position on PSRO		45	Report of Professionalism (Council of the OSMA)	No. 3
21	(Council of the Mahoning County Medical Society Clarification of Res. No. 23-74		46	Publication of Budget (Council of the OSMA)	No. 3
	(Gallia County Medical Society)		47	Affiliate Members (Council of the OSMA)	No. 3
22	Third Party Carriers (Sol Maggied, M.D., Delegate, Madison County)		48	Hearing of Resolutions Involving Ethics (Council of the OSMA)	No. 3
23	AMA Fiscal Responsibility (Academy of Medicine of Columbus and Franklin County) Continuing Medical Education		49	Abortion (N. M. Camardese, M.D., Delegate, Huron County Medical Society)	No. 3
24	Continuing Medical Education (Academy of Medicine of Columbus and Franklin County)	n No. 2	50	H. B. 682 (Sixth Councilor District)	No. 2

OSMA Hous

Attendance of Delegates

County	Delegate	First Session	Final Session	County	Delegate	First Session	Final Session
	FIRST DISTRICT			MARION	Paul E. Lyon	x	
ADAMS	Francis L. Stevens	x	x	MEDCED	Ernest Hetrick		x
BROWN	John Donohoo	x		MERCER SENECA	James Otis Walter Daniel	x x	x
BUTLER	Jerry D. Hammond	x	x	VAN WERT	A. C. Diller	x	x x
	James M. Smith James F. Stewart	x	x	WYANDOT	A. G. Dillei		
	Richard P. Burkhardt	x	x	WIMDOI			
CLERMONT	Carl A. Minning	x	x		FOURTH DISTRICT		
CLINTON	Foster J. Boyd	x		DEFIANCE	Paul E. Brose	x	
HAMILTON	John E. Albers	x	x		Ben Lenhart		x
	Frederick Brockmeier Eugene J. Burns	x x	x	FULTON	Benjamin H. Reed, Jr.	x	
	Edmund C. Casey	x	x	HENRY	Thomas F. Moriarty	x	
	Neal N. Earley	x	x	THOAG	Reynaldo C. Soriano		х
	Charles D. Feuss, Jr. George D. J. Griffin	x x	x x	LUCAS	John A. Devany C. Douglass Ford	x x	x x
	Robert S. Heidt	x	x		Roland A. Gandy, Jr.	x	x
	Harry K. Hines	x	x		B. Leslie Huffman	x	x
	H. Glenn Overley Glenn W. Pfister, Jr.	x x	x x		T. J. O'Grady Peter Overstreet	x x	x x
	William J. Schrimpf	x	x	OTTAWA	James I. Rhiel	x	•
	Andrew J. Weiss	x	x	OTIMWA	John Bodie	•	x
HICHI AND	Stewart B. Dunsker Glenn B. Doan	32	x x	PAULDING	Doyt E. Farling		x
HIGHLAND	Glenn b. Doan	х		PUTNAM	James Overmier	x	x
WARREN				SANDUSKY	Willis L. Damschroder	x	x
	SECOND DISTRICT			WILLIAMS	John A. Moats		x
CHAMPAIGN	Isador Miller	x	x	WOOD			
CLARK	Carlos O. Andarsio Ernest H. Winterhoff	x x	x		FIFTH DISTRICT		
	Henry A. Diederichs		x	ASHTABULA	Harold C. Franley	x	x
DARKE	Jesse L. Heise	x	x	CUYAHOGA	Edward J. Bishop	x	
GREENE	Antonio Mannarino		x		John H. Budd	x	x
MIAMI	A. Robert Davies	x	x		Charles L. Cassady Theodore J. Castele	x x	x x
MONTGOMERY	R. Alan Baker	x	x		Henry A. Crawford	x	x
	A. J. Gabriele	x	x x		Edward J. Kieger, II Edward G. Kilroy	x	x
	W. J. Lewis John H. Taylor	x x	x		John A. Kmieck	x x	x x
	Robert K. Finley, Jr.	x			Vincent T. LaMaida	x	x
	Konrad A. Kircher Frederic C. Schnebly	x x	x		George P. Leicht	x	x
	John R. Whitaker, Jr.	^	x		Leonard L. Lovshin Lawrence J. McCormack	x x	x x
PREBLE	Chester J. Brian		x		Hermann Menges	×	
SHELBY	George J. Schroer	x	x		George W. Petznick P. John Robechek	x x	x x
					Thomas P. Paras	x	x
	THIRD DISTRICT				John G. Poulos	x	x
ALLEN	J. M. Oppenheim	x	x		A. Benedict Schneider Franklyn J. Simecek	x x	x x
	David A. Barr	x	x		Frederick T. Suppes	x	x
AUGLAIZE					Nicholas DePiero		x
CRAWFORD	Johnson H. Chow	x	x		Roscoe J. Kennedy Howard S. VanOrdstrand		x x
HANCOCK	William Kose	x	x	GEAUGA	Bruce Andreas	x	x
HARDIN	Robert B. Elliott	x	x	LAKE	John A. Bukovnick	x	x
LOGAN	James H. Steiner	x	x		Wesley J. Pignolet	x	x

f Delegates

1975 Annual Meeting

County	Delegate	First Session	Final Session	County	Delegate	First Session	Final Session
County	SIXTH DISTRICT	Dession	bession	County	TENTH DISTRICT	Session	Session
COLUMBIANA	Leonard S. Pritchard	x	x	DELAWARE	Adelbert R. Callander	x	
MAHONING	J. James Anderson	x	x	FAYETTE	Joseph M. Herbert	x	x
	John C. Melnick	x	x	FRANKLIN	Homer A. Anderson	x	x
	Rashid A. Abdu Jack Schreiber	x x	x	TRIMINE	Michael A. Anthony	x	x
	J. W. Tandatnick	Α.	x		James E. Barnes	x	
PORTAGE	F. Michael Sheehan	x	x		Joseph A. Bonta Keith DeVoe, Jr.	x x	x x
STARK	E. Joel Davis	x	x		John N. Meagher	x	x
	Frank O. Goodnough Edward E. Grable	x	x		Jack E. Tetirick	x	x
	William A. White, Jr.	x x	x x		J. Hutchison Williams F. M. Kapetansky	x	x x
SUMMIT	Rocco M. Antenucci	x	x		H. William Porterfield	x	x
	Roy E. Bugay	x		KNOX	Henry Lapp	x	x
	Robert R. Clark Douglas M. Evans	x x	x x	MADISON	Sol Maggied	x	x
	W. Paul Kilway, Jr.	X	x	MORROW	David J. Hickson	x	x
	Joseph L. Kloss	x			•		
	Emmett P. Monroe	x		PICKAWAY	Robert G. Smith	х	х
	William Dorner, Jr. Charles East		x x	ROSS	Richard Counts	x	x
	James G. Roberts		x	UNION	John R. Linscott	x	
TRUMBULL	Joseph L. Logan	x	x				
	Robert J. Paul	x	х		ELEVENTH DISTRICT		
	SEVENTH DISTRICT			ASHLAND	John Cooperrider	x	x
BELMONT	Felipe V. Lavapies	x	x	ERIE	S. Baird Pfahl, Jr.	x	x
CARROLL	Carl A. Lincke	x	x	HOLMES	Luther High	x	x
COSHOCTON	Robert R. Johnson	x	x	HURON	Nino M. Camardese	x	x
HARRISON	Elias Freeman	x	x	LORAIN	Charles C. Adams	x	x
JEFFERSON	Janis Trupovnieks Sanford Press	x	x		Delbert L. Fischer	x	x
MONROE	Donald Piatt	x	x		Harold E. McDonald	х	x
TUSCARAWAS	Philip T. Doughten		x	MEDINA	Richard Avery	x	x
	EIGHTH DISTRICT			RICHLAND	Harold F. Mills James W. Wiggin	x x	x x
ATHENS	John F. Kroner	x	x	WAYNE	A. Burney Huff	x	x
FAIRFIELD	James Merk		x				
GUERNSEY	Robert Ringer	x	x		OFFICERS		
LICKING	John P. Anderson, Jr.	x	x		(Members of the Council)		
MORGAN	Henry Bachman		x	D. 11	`		37
MUSKINGUM	W. B. Devine	x	х	President President-Elect	James L. Henry Maurice F. Lieber	x x	x x
NOBLE				Past President	Oscar W. Clarke	x	x
PERRY WASHINGTON	Gregory Krivchenia	x	x	Secretary- Treasurer	William M. Wells	х	х
				First District	Stephen P. Hogg	x	x
	NINTH DISTRICT			Second Third	James G. Tye John C. Smithson	x x	x x
GALLIA	Edward J. Berkich	x		Fourth	George N. Bates	x	x
HOCKING	Thomas P. Price Lethia Starr	**	X	Fifth	John J. Gaughan	x	x
HOCKING JACKSON	Carl J. Greever	x x	x x	Sixth Seventh	C. Edward Pichette Robert E. Rinderknecht	x x	x x
LAWRENCE	A. Burton Payne	x	x	Eighth	Richard E. Hartle	x	x
MEIGS	Roger P. Daniels	x	x	Ninth	Thomas W. Morgan	x	x
PIKE				Tenth Eleventh	James C. McLarnan Robert G. Thomas	x x	x x
SCIOTO	Chester H. Allen	x	x	Eleventii	Robert G. Thomas		
VINTON					TOTAL	160	162

Proceedings of the House of Delegates 1975 Annual Meeting

MINUTES OF FIRST SESSION

The first session of the House of Delegates of the Ohio State Medical Association was convened at 7:00 p.m., Sunday, May 11, 1975, at the Sheraton-Columbus Hotel, Columbus, with President James L. Henry, Presiding.

The Invocation was offered by Fr. Robert P. Neumeyer, Catholic Chaplain of Aultman Memorial Hospital, Canton.

Dr. J. Hutchison Williams, President of the Academy of Medicine of Columbus and Franklin County, welcomed the delegates and guests to Columbus.

Report on Delegates Present

Dr. B. Leslie Huffman, Jr., Maumee, Chairman of the Credentials Committee, reported that out of 174 delegates eligible to vote, 160 were seated. A number of alternate-delegates, guests, officers of county medical societies and executive secretaries were in attendance.

1974 Minutes Approved

The minutes of the 1974 sessions of the House of Delegates, as published in the July, 1974, issue of **The Ohio State Medical Journal, were approved** by official action.

Introduction of Guests

Dr. Henry introduced the following guests:

Mr. Edward Roberto, Georgetown, Chairman of the Board, Ohio Hospital Association; Karleen A. Streitenberger, R.N., Columbus, Second Vice President, Ohio Nurses Association; Mr. William L. Howland, L.L.B., Portsmouth, President, Ohio State Bar Association; George R. Blind, D.V.M., Barberton, President, Ohio Veterinary Medical Association; Carl E. Spragg, M.D., New Concord, President, Ohio Academy of Family Physicians; Mrs. Howard Liljestrand, Honolulu, Hawaii, President, Woman's Auxiliary to the American Medical Association, and Dr. Liljestrand; Mrs. S. J. Glueck, Springfield, President, Woman's Auxiliary to the Ohio State Medical Association; Mrs. Robert Krone, Cincinnati, President-Elect, Woman's Auxiliary to the OSMA; Mrs. Joan Ray, Columbus, President, Ohio State Society of Medical Assistants; Dr. John H. Ackerman, Columbus, Director, Ohio Department of Health; Dr. Timothy B. Moritz, Columbus, Director, Ohio Department of Mental Health and Mental Retardation; Mr. James E. Pohlman, Esq., OSMA Legal Counsel; Mr. Charles S. Nelson, Columbus and Mr. George H. Saville, Columbus, both OSMA Honorary Members.

OSMA Past Presidents Introduced

The following Past Presidents of the Association were introduced: Dr. Carl A. Lincke, Carrollton; Dr. Charles L. Hudson, Cleveland; Dr. Richard L. Meiling, Columbus; Dr. Frank H. Mayfield, Cincinnati; Dr. George W. Petznick,

Cleveland; Dr. Robert E. Tschantz, Canton; Dr. Henry A. Crawford, Cleveland; Dr. Robert E. Howard, Cincinnati; Dr. Theodore L. Light, Dayton; Dr. Robert N. Smith, Toledo; Dr. Richard L. Fulton, Columbus; Dr. P. John Robechek, Cleveland; Dr. William R. Schultz, Wooster, and Dr. Oscar W. Clarke, Gallipolis.

Also introduced were former members of the Council; Dr. Chester H. Allen, Portsmouth; Dr. Dwight L. Becker, Lima; Dr. Philip B. Hardymon, Columbus; Dr. Paul F. Orr, Perrysburg; Dr. Sanford Press, Steubenville, and Dr.

George J. Schroer, Ft. Loramie.

Introduction of AMA Board of Trustees Member

Dr. Henry next introduced Dr. John H. Budd, Cleveland, a member of the Board of Trustees of the American Medical Association.

Thanks Expressed

Dr. Henry expressed the thanks of the Ohio State Medical Association to Dr. Jack E. Tetirick, Chairman, and to the members of the Committee on Scientific Work for their contributions in planning the 1975 meeting.

Report of Woman's Auxiliary President

Mrs. S. J. Glueck, Springfield, President of the Woman's Auxiliary to the Ohio State Medical Association, came to the podium to address the House of Delegates on various activities of the Woman's Auxiliary during the last year. Mrs. Glueck said special emphasis was given to the legislative, mental health, OMPAC and health education programs. She also discussed the cooperation between the OSMA and the Auxiliary. (See Page 483).

Remarks of Ohio Society of Medical Assistants President

Mrs. Joan Ray, Columbus, President of the Ohio Society of Medical Assistants, came forward to discuss the activities of the Medical Assistants, especially the Office Management Seminar and the continuing education program of the Society.

AMA-ERF Checks Presented

Dr. Philip B. Hardymon, Columbus, Chairman of Ohio's Committee for the American Medical Association's Education and Research Foundation, made the presentation of the AMA-ERF checks, as follows:

Dr. Frederick T. Suppes, Faculty, Case Western Reserve School of Medicine, Cleveland (Check for \$7,836.12).

Dr. Stephen P. Hogg, First District Councilor, accepting for the University of Cincinnati College of Medicine, Cincinnati (Check for \$11,943.92).

Dr. Henry G. Cramblett, Dean, The Ohio State University, College of Medicine, Columbus (Check for \$14.904.69).

Dr. John P. Kemph, Dean, Medical College of Ohio at

Toledo, Toledo (Check for \$5,512.97).

Dr. John R. Beljan, Dean, Wright State University School of Medicine. Dayton (Check for \$685.00).

Dr. Stanley W. Olson, Dean, Northeastern Ohio Universities College of Medicine, Kent (Check for \$792.42).

Presentation of Special Award

Dr. Henry presented to Dr. Gordon M. Todd, Toledo, Past Chairman of the Board of Ohio Medical Indemnity, Inc., a special award in appreciation of his service as Chairman of the Board of Directors of Ohio Medical Indemnity, Inc.

Plaques and Certificates of Appreciation

Dr. Oscar W. Clarke, Gallipolis and Dr. James C. McLarnan, Mt. Vernon, received plaques in appreciation for their service to the Association, as retiring members of the Council

A certificate of appreciation was presented to Dr. Jack E. Tetirick, Columbus, for his service as chairman of the Standing Committee on Scientific Work. Dr. Robert E. Heilman, Columbus, was presented a certificate of appreciation, for his service as a member of the Standing Committee on Education.

The following retiring chairmen of special committees were honored: Dr. George N. Bates, Toledo, Committee on Auditing and Appropriations and Council Fee Review Committee; Dr. Oscar W. Clarke, Gallipolis, OSBA/OSMA Liaison Committee and MAI, OFMC, OMI Committee; Dr. Richard E. Hartle, Lancaster, Council Fee Review Committee; Dr. William H. Havener, Columbus, Committee on Pharmacy; Dr. Carey B. Paul, Columbus, Joint Advisory Committee on School Bus Driver Examinations; Dr. William V. Trowbridge, Cleveland, Committee on Workmen's Compensation, and Dr. William M. Wells, Newark, Committee on Podiatry Relations.

Dr. Lawrence C. Meredith, Oberlin, was presented a certificate of appreciation for his service to the Association, as a retiring member of the OSMA Delegation to the AMA.

Dr. Henry then presented certificates to the Life Active Members: Dr. Chester H. Allen, Portsmouth: Dr. Herbert E. Bean, Columbus; Dr. Janet K. Bixel, Columbus; Dr. Henry C. Chalfant, Ashland; Dr. Vera Clem Chalfant, Ashland; Dr. Oscar W. Clarke, Gallipolis; Dr. Laurence L. Cockerille, Jr., Parma; Dr. Walter A. Daniel, Tiffin; Dr. Richard L. Dobbins, Celina; Dr. John J. Gaughan, Cleveland; Dr. Carl J. Greever, Jackson; Dr. L. David Hall, Columbus; Dr. James L. Henry, Grove City; Dr. Ernest W. Hetrick, Marion; Dr. Paul A. Jones, Zanesville; Dr. William A. Millhon, Columbus; Dr. Edward L. Mitchell, Alliance; Dr. Thomas W. Morgan, Gallipolis; Dr. A. Burton Payne, Ironton; Dr. Kirkwood A. Pritchard, Paulding; Dr. Geeta Srinivas, Cleveland; Dr. Philip C. Stiff, Toledo; Dr. Edward R. Thomas, Dayton; Dr. Robert G. Thomas, Elyria; and Dr. Thomas C. Versic, Cincinnati.

Presentation of Distinguished Service Citations

Dr. Richard L. Meiling, Columbus, and Dr. Robert M. Zollinger, Columbus, were named recipients of the Distinguished Service Citations. The citations were presented in recognition of their many contributions in their respective fields. Both physicians were given standing ovations as they accepted the awards and expressed their thanks.

Reference Committees Appointed

The following House of Delegates Reference Commit-

tees were appointed by the President:

Credentials of Delegates — B. Leslie Huffman, Chairman, Lucas County; Andrew J. Weiss, Hamilton County; W. J. Lewis, Montgomery County; F. Michael Sheehan, Portage County; Chester H. Allen, Scioto County, and Homer A. Anderson, Franklin County.

President's Address — Thomas W. Morgan, Chairman, Gallia County; P. John Robechek, Cuyahoga County, and

George D. J. Griffin, Hamilton County.

Tellers and Judges of Election — Charles East, Chairman, Summit County; Carlos O. Andarsio, Clark County; Richard Wiseley, Lucas County; Howard S. Van Ordstrand, Cuyahoga County; Leonard S. Pritchard, Columbiana County; Richard L. Fulton, Franklin County, and Wendell M. Bell. Richland County.

Resolutions Committee No. 1 — David A. Barr, Chairman, Allen County; Glenn B. Doan, Highland County; Ernest H. Winterhoff, Clark County; Benjamin H. Reed, Jr., Fulton County; Lawrence J. McCormack, Cuyahoga County; Rocco M. Antenucci, Summit County, Philip T. Doughten, Tuscarawas County; John F. Kroner, Athens County; A. Burton Payne, Lawrence County; James E. Barnes, Franklin County, and A. Burney Huff, Wayne County.

Resolutions Committee No. 2 — Robert B. Elliott, Chairman, Hardin County; Jerry D. Hammond, Butler County; A. Robert Davies, Miami County; Willis L. Damschroder, Sandusky County; Theodore J. Castele, Cuyahoga County; J. James Anderson, Mahoning County; Robert R. Johnson, Coshocton County; W. B. Devine, Muskingum County; Roger P. Daniels, Meigs County; Henry Lapp, Knox County, and S. Baird Pfahl, Jr., Erie County.

Resolutions Committee No. 3 — J. Hutchison Williams, Chairman, Franklin County; Eugene J. Burns, Hamilton County; R. Alan Baker, Montgomery County; James Otis, Mercer County; Thomas F. Moriarty, Henry County; Wesley J. Pignolet, Lake County; Edward E. Grable, Stark County; Donald Piatt, Monroe County; Robert Ringer, Guernsey County, Kenneth E. Wilkinson, Pike County, and Harold F. Mills, Richland County.

Election of Committee on Nominations

The House of Delegates nominated and elected the following persons, one from each district, for the Committee on Nominations:

First District — Robert S. Heidt, Hamilton County.

Second District — George J. Schroer, Shelby County.

Third District — Walter Daniel, Seneca County.

Fourth District — C. Douglass Ford, Lucas County.

Fifth District — Frederick T. Suppes, Cuyahoga Coun-

ty.

Sixth District — Leonard S. Pritchard, Columbiana County.

Seventh District — Elias Freeman, Harrison County. Eighth District — John P. Anderson, Jr., Licking County.

Ninth District — Lethia Starr, Hocking County. Tenth District — Jack E. Tetirick, Franklin County. Eleventh District — Luther High, Holmes County.

Dr. Henry then announced that under the system of rotation approved by the House of Delegates in 1963, the chairman of the Committee this year would be the delegate from the Second District, Dr. George J. Schroer, Shelby County.

President's Address

Mr. Page then introduced President James L. Henry, Grove City, who delivered his Presidential Address. (Text of the address appears on page 471)

After the Address, the House gave Dr. Henry a standing

ovation.

Introduction of Resolutions

Dr. Henry then ruled that since the resolutions, which had been presented within the 60-day time limit, had been distributed to the delegates in advance of the meeting, it would not be necessary to read the titles on the floor of the House. The House of Delegates approved this ruling.

Report of the Committee on Emergency Resolutions

The Committee on Emergency Resolutions, consisting of the chairmen of the three resolutions committees, met to consider two emergency resolutions, one submitted by the Sixth Councilor District, and the other submitted by the Academy of Medicine of Toledo and Lucas County. It was the opinion of the Committee that both resolutions did qualify as justified Emergency Resolutions. However, before the House of Delegates went into session, the resolution submitted by the Academy of Medicine of Toledo and Lucas County was withdrawn. The resolution submitted by the Sixth Councilor District was assigned by the Committee to Resolutions Committee No. 2, and was numbered "Resolution No. 50-75."

By official action, the report was adopted.

Introduction of Out-of-State Guest

Dr. Henry introduced the following out-of-state guest: Dr. Jack Leckie, President-Elect, West Virginia State Medical Association, Huntington, West Virginia.

House Recessed

The House then recessed until the final session, 3:30 p.m., Wednesday, May 14.

MINUTES OF THE FINAL SESSION

The final business session of the House of Delegates convened at 3:30 p.m., Wednesday, May 14, at the Sheraton-Columbus Hotel.

President Henry presented a statement on recent developments with regard to House Bill 682, the professional liability proposal in the Ohio General Assembly.

Report of Credentials Committee

Dr. B. Leslie Huffman, Jr., Lucas County, Chairman of the Committee on Credentials, reported that out of 174 delegates eligible to vote, 162 were seated.

President Commended

Dr. Robert S. Heidt, Cincinnati, asked for the privilege of the floor and commended President Henry for the excellent manner in which he presided over the First Session of the

Election of President-Elect

Dr. Henry called for nominations for the office of President-Elect. Dr. John A. Devany, Toledo, placed in nomination Dr. George N. Bates, Toledo, Lucas County, Councilor of the Fourth District. The nomination was duly seconded. There were no other nominations and Dr. Bates was elected by acclamation. Dr. Bates came to the rostrum and presented a brief statement of acceptance of the responsibilities of office.

Report of Nominating Committee

Dr. George J. Schroer, Delegate, Shelby County, Chairman, Committee on Nominations, presented the report of the Nominating Committee, as follows:

Councilors Second District

As Councilor of the Second District to succeed Dr. James G. Tye, Dayton, the Committee placed in nomination Dr. W. J. Lewis, Dayton, Ohio. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Lewis was declared elected Councilor of the Second District for a term of two years, 1975-1976 and 1976-1977.

Fourth District

As Councilor of the Fourth District to succeed Dr. George N. Bates, Toledo, the Committee placed in nomination Dr. C. Douglass Ford, of Toledo, Ohio. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Ford was declared elected Councilor of the Fourth District for a term of two years, 1975-1976 and 1976-1977.

Sixth District

As Councilor of the Sixth District to succeed himself, the Committee placed in nomination Dr. C. Edward Pichette, of Youngstown. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Pichette was

declared reelected Councilor of the Sixth District for a term of two years, 1975-1976 and 1976-1977.

As Councilor of the Eighth District to succeed himself, the Committee placed in nomination Dr. Richard E. Hartle, of Lancaster. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Hartle was declared reelected Councilor of the Eighth District for a term of two years, 1975-1976 and 1976-1977.

Tenth District

As Councilor of the Tenth District to succeed Dr. James C. McLaman, Mt. Vernon, the Committee placed in nomination Dr. J. Hutchison Williams, Columbus, The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Williams was declared elected Councilor of the Tenth District for a term of two years, 1975-1976 and 1976-1977

AMA Delegates

Dr. Schroer then presented the nominees for the office of delegate to the American Medical Association for a term of two years beginning January 1, 1976; Drs. Oscar W. Clarke, Gallipolis: Henry A. Crawford, Cleveland: Harry K. Hines, Cincinnati; W. J. Lewis, Dayton, and P. John Robechek, Cleveland. The nominations were duly seconded and there were no further nominations from the floor, Drs. Clarke, Crawford, Hines, Lewis and Robechek were reelected delegates to the American Medical Association for a term of two years, beginning January 1, 1976.

Dr. Schroer then presented the nominees for the office of delegate to the American Medical Association for a term of one year beginning May 14, 1975 and ending December 31, 1976, to fill a vacancy: Dr. H. William Porterfield, Columbus, and Dr. Jack Schreiber, Canfield. Both nominations were duly seconded and a secret ballot taken. Dr. H. William Porterfield was declared elected on the second ballot to the unexpired portion of the term.

AMA Alternate Delegates

For alternate delegates to the American Medical Association for a term of two years beginning January 1, 1976, the Nominating Committee placed in nomination the names of Drs. George N. Bates, Toledo; Richard L. Fulton, Columbus; Jerry L. Hammon, West Milton; Jack Schreiber, Canfield; Robert G. Thomas, Elyria; John J. Gaughan, Cleveland, and Charles D. Feuss, Cincinnati. The nominations were duly seconded and a secret ballot taken. Drs. Bates. Fulton, Hammon, Schreiber, and Gaughan were declared alternate delegates to the American Medical Association for a term of two years, beginning January 1, 1976.

For the one year term to fill the vacancy created by Dr. Porterfield being elected delegate, Drs. Robert G. Thomas, Elyria, and Dr. Charles D. Feuss, Cincinnati were nominated. Both nominations were seconded and a secret ballot taken. Dr. Thomas was declared elected on the first ballot to the unexpired portion of the term, beginning May 14, 1975

and ending December 31, 1976.

The report of the Nominating Committee was approved.

Committee on President's Address

Dr. Henry then called for the report of the Reference Committee on President's Address (see page 471), which was presented by Dr. Thomas W. Morgan, Gallia County, Chairman of the Committee. The report read as follows:

"After expressing appreciation for the opportunity to serve the Association, President Henry appropriately reviewed the list of expanded services provided by the Ohio State Medical Association, made possible by the dues increase implemented January 1 of this year. He also referred proudly to our new headquarters building and to the advantages which it provides over our erstwhile rental status. President Henry then dwelled at length on the various dichotomies within the organization emphasizing the dangers of fragmentation and the necessity for unity lest federal efforts to assert control benefit by default from our divided house. More specifically his call for unequivocal clarification of Amended Resolution 23-74 is entirely proper because of the controversy and divisiveness which have resulted from variable interpretations of the intent of this Resolution. His reference to the charter of the Ohio State Medical Association written in 1904 is likewise most appropriate since it reemphasizes that unity was and remains a prime reason for the existence and a prerequisite for the effectiveness of our organization since its inception.

"The positive benefits of unity have never been more clearly demonstrated than by the rapid progress which has seemed to accompany our cohesive efforts to resolve the

professional liability issue.

'This Committee considers that President Henry's address was particularly noteable in that sincerity dominated

both its delivery and content.

"Respectifully submitted, Committee on the President's Address: George D. J. Griffin, Hamilton County; P. John Robechek, Cuyahoga County; Thomas W. Morgan, Gallia County, Chairman,

On a motion made and seconded, the House of Delegates, by offical action, approved the report of the Reference Committee on President's Address.

Report of Resolutions Committee No. 1

Dr. David A. Barr, Allen County, reported for Resolutions Committee No. 1, of which he was chairman. The report read as follows:

"Resolutions Committee No. 1 met and considered the resolutions which were presented to it. We met in open session from 8:30 a.m. until 1:30 p.m. and in executive

session from 2:30 p.m. until 5:15 p.m.

"Our Committee was presented with resolutions which fell into basically two subjects, the first being professional liability and the second being professional standards review organizations and related peer review questions. We decided, as a Committee, to consider grouping our resolutions and they fell into six different groups.

"The first group was Resolutions 1 through 4, which concerned themselves with professional liability. We heard a great deal of testimony concerning professional liability in

support of all four resolutions.

"We heard reference made to H.B. 682, which is the bill introduced into the Ohio Legislature and is referred to as the Omnibus Malpractice Bill. We feel that this represents an effort and a beginning in the malpractice problem, but that certain areas of the bill require attention and support while others require modification. We would commend this bill to this House as a beginning in a final over-all solution of the professional liability problem.

RESOLUTION NO. 1-75 Professional Liability

"The committee then considered Resolution No. 1, presented by the Academy of Medicine of Columbus and Franklin County, entitled 'Professional Liability.'

"Since there were editorial changes in this resolution, I will read the resolution:

AMENDED RESOLUTION NO. 1-75 Professional Liability

- WHEREAS, Officials of the Ohio State Medical Association have fully recognized the critical nature of the professional liability crisis in a letter to the membership dated January 31, 1975; and
- WHEREAS, Ohio State Medical Association has given highest priority to reaching lasting remedial solutions; and
- WHEREAS, Officials of the Ohio State Medical Association have outlined a step-by-step progress report and plans for sound, lasting, unified, remedial action in a letter to the membership dated February 28, 1975; and
- WHEREAS, The Ohio State Medical Association House of Delegates is convinced that officials of the Ohio State Medical Association have an action program that, if wholeheartedly supported by the Ohio State Medical Association members and other interested parties, will succeed; THEREFORE, BE IT
- RESOLVED, That the Ohio State Medical Association House of Delegates commend the Ohio State Medical Association officials for their diligent effort and progress in attempting to reach a lasting solution to this critical problem; and BE IT FURTHER
- RESOLVED, That the Ohio State Medical Association House of Delegates encourage Ohio State Medical Association officials to continue their efforts to reach a lasting solution to this critical problem in order to enable the physicians of Ohio to continue to deliver quality health care to the citizens of Ohio.

"Mr. Chairman, your Resolutions Committee recommends and I move adoption of Resolution No. 1-75 as amended, editorially."

By official action, the House voted to adopt Amended Resolution No. 1-75.

RESOLUTIONS NOS. 2-75, 3-75 and 4-75

"Next considered were Resolutions Nos. 2-75, 3-75 and 4-75, presented by the Academy of Medicine of Cleveland and Cuyahoga County, Holmes County Medical Society and Alford C. Diller, M.D., Delegate from Van Wert County, respectively.

"The Committee felt that while all three of these resolutions presented various aspects to solutions of professional liability, combining them into a single resolution would be

more reasonable and more acceptable.

"Therefore, the Committee wishes to present the following substitute resolution, which reads as follows:

AMENDED SUBSTITUTE RESOLUTION NO. 2-75 Professional Liability Commission

WHEREAS, professional liability is a serious and continuing problem for patients and physicians alike; THEREFORE, BE IT

- RESOLVED, That an appropriate committee of the Ohio State Medical Association be charged, by the Council, with the responsibility for investigation, evaluation and appropriate action concerning the following problems:
 - Availability and reasonable pricing of professional liability insurance
 - 2. Arbitration
 - 3. Limitation of awards
 - 4. Physician exposure
 - 5. Liability review commission
 - 6. Development of a data bank in regard to actuarial statistics of professional liability insurance carriers
 - 7. Defendant recourse-counter suits
 - 8. Contingency fees
 - 9. Professional and public education

and, BE IT FURTHER

RESOLVED, That such committee provide continuing reports to the House of Delegates and, when appropriate, to the membership as a whole, AND, BE IT FURTHER

- RESOLVED, THAT THIS HOUSE OF DELEGATES CHARGE COUNCIL WITH IMMEDIATE FORMATION OF CONTINGENCY PROGRAMS TO FURTHER DEAL WITH THE PROFESSIONAL LIABILITY DILEMMA, SUCH AS, BUT NOT INCLUSIVE:
 - 1. BINDING ARBITRATION
 - 2. CEILING ON AWARDS
 - 3. NON-BINDING PROFESSIONAL REVIEW COM-MISSION WITH OPINIONS ADMISSIBLE IN COURT
 - 4. RECOVERY OF ATTORNEY FEES FOR WRONGLY ACCUSED PHYSICIANS
 - 5. RECOVERY OF COUNTER CLAIM DAMAGES BY WRONGLY ACCUSED PHYSICIAN
 - EXPLORATION OF PHYSICIAN OWNED INSUR-ANCE COMPANY
 - "Mr. Chairman, your Resolutions Committee recom-

mends and I move the adoption of Substitute Resolution No. 2-75."

By official action, the House voted to amend Substitute Resolution No. 2-75 as indicated by the strike-out deletion, and by the additions set forth in capital letters, then adopted it.

RESOLUTION NO. 5-75

"Resolution No. 5-75 was next considered by the Committee. This resolution was introduced by the Academy of Medicine of Cleveland and Cuyahoga County. Editorial changes were made and the amended resolution reads as follows:

AMENDED RESOLUTION NO. 5-75 Norms or Criteria of Medical Care

- WHEREAS, Various federal laws or regulations require the development and use of regional 'norms,' criteria, or standards of medical care as criteria for determining 'acceptable' quality and utilization of medical services; and
- WHEREAS, The application of rigid norms, criteria and standards will result in unnecessary procedures for some patients and could discourage necessary or desirable procedures for other patients; THEREFORE, BE IT
- RESOLVED, That any such norms, standards, or criteria, regardless of origin, be considered only as guidelines to good medical care and not as rigid requirements for diagnostic or therapeutic procedures.

"Mr. Chairman, your Resolutions Committee recommends and I move adoption of Resolution No. 5-75 as amended."

By official action, the House voted to adopt Amended Resolution No. 5-75.

AMENDED RESOLUTION NO. 6-75 HEW Regulations in Regard to Utilization Review Under the Social Security Act.

"We next considered Resolution No. 6-75, introduced by the Academy of Medicine of Cleveland and Cuyahoga County, entitled 'HEW Regulations in Regard to Utilization Review Under the Social Security Act.'

"There was much discussion concerning this resolution and the Committee felt that it reflected certain views well but we wish to amend the resolution by removing the second 'RESOLVED,' and deleting the last phrase in the third resolve. The resolution will read, starting with the first 'RESOLVED,' as follows:

RESOLVED, That the Ohio State Medical Association commend the American Medical Association for its forthright action in pursuing this legal course in defense of the rights of patient and physician and, if it be prudent and proper, join with it as a party or amicus curiae to this action; and BE IT FURTHER

RESOLVED, THAT THE MEMBERSHIP OF THE OHIO STATE MEDICAL ASSOCIATION BE INFORMED OF

THE UNDESIRABLE EFFECTS OF THESE REGULATIONS AND THE MERITS OF THE AMA LAWSUIT ARGUMENTS, AND THAT MEMBERS BE ADVISED OF THEIR RIGHTS UNDER THE LAW AND ITS REGULATIONS TO DECLINE TO PARTICIPATE IN THE GOVERNMENT-MANDATED REVIEW AND CERTIFICATION AND THAT PHYSICIANS AND HOSPITAL ADMINISTRATORS BE INFORMED OF PERMISSIBLE ALTERNATIVES TO MEDICAL STAFF PERFORMANCE OF THIS ACTIVITY, AND BE IT FURTHER

RESOLVED, That physicians through their various hospital medical staff committees continue to perform peer review as in the past, directed to increasing the quality of patient care and reducing its cost.

"Mr. Chairman, your Resolutions Committee recommends and I move adoption of Amended Resolution No. 6-75."

By official action, the House voted to amend Amended Resolution No. 6-75 as indicated by the additions set forth in capital letters, then adopted it.

RESOLUTION NO. 7-75

Employ Non-Staff Physicians to Do PSRO, Utilization Review, Certification and Review

"Resolution No. 7-75, introduced by the Academy of Medicine of Cleveland and Cuyahoga County, entitled 'Employ Non-Staff Physicians to do PSRO, Utilization Review, Certification and Review,' was considered by the Committee. It was felt that it added nothing to the previous resolution and was somewhat ambiguous.

"Mr. Chairman, your Resolutions Committee recommends and I move that Resolution No. 7-75 be not adopted"

By official action, the House voted to reject the committee's recommendation on Resolution No. 7-75, and the following Substitute Resolution No. 7-75 was introduced:

SUBSTITUTE RESOLUTION NO. 7-75

- WHEREAS, The House of Delegates of the AMA, June 1974, Chicago, Illinois, Resolution 89 which states 'Resolved, That the Association should continue its efforts to achieve legislation which allows the profession to perform peer review in accordance with the profession's philosophy and the best interests of the patient; and
- WHEREAS, Peer review as mandated by 89-97 (Medicare-Medicaid Law) especially section 1861 (K)(2)(B) offers alternative methods of implementation of utilization certification and review; THEREFORE, BE IT
- RESOLVED, That the Council of the Ohio State Medical Association inform the members of the Ohio State Medical Association of all options available to them under Public Law 89-97; and BE IT FURTHER
- RESOLVED, That option three of Section (K)(2)(B) of Public Law 89-97 is available which would allow non-staff

physicians to do utilization, certification and review.

By official action, the House voted adoption of the Substitute Resolution No. 7-75.

RESOLUTION NO. 8-75 PSRO Information and Confidentiality (A)

"Resolution No. 8-75 was next considered. It was introduced by the Academy of Medicine of Toledo and Lucas County, entitled 'PSRO Information and Confidentiality (A)."

"A great deal of testimony was heard concerning confidentiality of information gathered during professional standards review, peer review or utilization review process, or during a certification procedure. This resolution presents an idea that the Committee felt was unassailable.

"Mr. Chairman, your Resolutions Committee recommends and I move adoption of Resolution No. 8-75 as submitted."

RESOLUTION NO. 8-75 PSRO Information and Confidentiality (A)

- WHEREAS, Section 249F. of Public Law 92-603 (The PSRO Act of 1972) was implemented to facilitate quality medical care and control costs; and
- WHEREAS, Quality and cost control considerations are often mutually exclusive; THEREFORE, BE IT
- RESOLVED, That where direct conflict between quality and cost control purposes exists, that quality medical care be recognized as the higher social value.

By official action, the House voted to adopt Resolution No. 8-75.

RESOLUTIONS NOS. 9-75, 10-75, 11-75, 12-75, 13-75

"Next considered by the Committee was a grouping of resolutions, including Resolutions Nos. 9-75, 10-75, 11-75, 12-75 and 13-75. All of these resolutions were introduced by the Academy of Medicine of Toledo and Lucas County and all are entitled 'PSRO Information and Confidentiality,' and are lettered B through F.

"These resolutions were felt to represent, again, the issue of confidentiality of information collected in the various review functions, whether by hospital staffs or federally funded programs or locally run programs. The Committee felt that a substitute resolution would bring together the ideas presented in a more workable form for this House to consider.

"Therefore, Substitute Resolution No. 9-75, reads as follows:

SUBSTITUTE RESOLUTION NO. 9-75 PSRO Information and Confidentiality

WHEREAS, Section 249F of Public Law 92-603 (The PSRO Act of 1972) grants the Secretary of HEW broad inspection powers; THEREFORE, BE IT

RESOLVED, That absolute confidentiality be maintained in regard to records pertaining to patients, PSRO, utilization review and physicians.

"Mr. Chairman, your Resolutions Committee recommends and I move adoption of Substitute Resolution No. 9-75."

By official action, the House voted to adopt Substitute Resolution No. 9-75

RESOLUTIONS NOS. 14-75, 17-75 and 21-75

"We next considered a grouping of resolutions, including Resolution No. 14-75, introduced by the Ross County Medical Society, entitled 'Exploitation of Physicians,' Resolution No. 17-75, introduced by the Council of the Ohio State Medical Association, entitled 'OSMA Position on PSRO,' and resolution No. 21-75, introduced by the Gallia County Medical Society, entitled 'Clarification of Resolution No. 23-74'

Following a great deal of discussion in the open hearing and a great deal of discussion in the executive session, the action on these three resolutions was taken in this manner:

RESOLUTION NO. 17-75

"There were editorial changes made by a member of the Council which will appear in the resolution as I read it. Also, the Committee recommended an amendment to the resolution by deletion of the sixth 'RESOLVED,' thereby putting a period following the word 'program' in the last line of the fifth 'RESOLVED.'

AMENDED RESOLUTION NO. 17-75 Peer Review Programs

- WHEREAS, The medical profession has traditionally been dedicated to preserving and maintaining the highest quality medical care and appropriate level of care; and
- WHEREAS, The medical profession has traditionally supported self-regulatory bodies and programs; and
- WHEREAS, Physician peer review programs have been a long standing part of the self-regulatory programs to ensure appropriate quality and appropriate level of care; and
- WHEREAS, Accountability is a recognized characteristic in contemporary society; and
- WHEREAS, Confusion has developed as to the proper meaning and construction to be given to previous resolutions adopted by the House of Delegates concerning PSRO, MAI-Peer Review Systems, and P.L. 92-603; THEREFORE, BE IT
- RESOLVED, That the House of Delegates instruct the Council to continue its efforts, in cooperation with county medical societies of Ohio, other state medical associations and the American Medical Association, to achieve constructive amendments to P.L. 92-603 and to ensure

appropriate regulations and directions by the Secretary of HEW, with particular emphasis directed at amending those sections of the law that present potential dangers in the areas of confidentiality, professional liability, development of norms of practice, quality of care, and the authority of the Secretary of HEW, and BE IT FURTHER

RESOLVED, That the Ohio State Medical Association should, in cooperation with county medical societies in Ohio, other state medical associations and the American Medical Association, continue its efforts to achieve legislation that allows the medical profession to perform peer review in accordance with the profession's philosophy and in the best interests of the patient; and BE IT FURTHER

RESOLVED, That the House of Delegates direct the Council to request MAI Peer Review Systems to continue its consultative and supportive role and its work in developing medically oriented peer review programs, criteria and methodologies, in assisting county medical societies and individual members of OSMA who elect to participate in the development and operation of clinical peer review programs approved by local medical societies, including, but not limited to, programs which implement the review provisions of P.L. 92-603; and BE IT FURTHER

RESOLVED, That component county medical societies and/or individual members of OSMA who elect not to participate in the implementation of P.L. 92-603 should not be precluded from adopting and maintaining such a position by this resolution, but should be encouraged to develop effective non-PSRO peer review programs that embody the principles endorsed by the medical profession as constructive alternatives to PSRO; and BE IT FURTHER

RESOLVED, That, when evaluation of the PSRO program by the House of Delegates and/or the Council reveals that it adversely affects the quality of patient care or conflicts with the principles of medical ethics, the Council is instructed to use all PROFESSIONAL AND legal means to rectify such shortcomings of the PSRO program.

"Mr. Chairman, your Resolutions Committee recommends and I move adoption of Amended Resolution 17-75."

On motion by C. Douglass Ford, Toledo, duly seconded, the House voted to limit debate to 30 minutes on Amended Resolution No. 17-75, with three minutes allotted each discussant.

By official action, the House voted to amend Amended Resolution No. 17-75 as indicated by the additions set forth in capital letters, then adopted it.

RESOLUTION NO. 21-75 Clarification of Resolution No. 23-74

"Next considered was Resolution No. 21-75, introduced by the Gallia County Medical Society, entitled 'Clarification of Resolution No. 23-74. "With an editorial change in the second line of the first "WHEREAS," this resolution was felt to be relevant. The word 'control' should be stricken and the word 'involve' inserted.

"Mr. Chairman, your Resolutions Committee recommends and I move adoption of Resolution 21-75."

AMENDED RESOLUTION NO. 21-75 Clarification of Resolution No. 23-74

WHEREAS, Resolution 23-74 <u>advises</u> OSMA members 'not to involve themselves in the implementation of any form of government controlled Peer Review as exemplified by the Professional Standards Review Section of P.L.92-603;' and

WHEREAS, Many OSMA members have elected to participate in PSRO activities in conformity with P.L. 92-603; and

WHEREAS, OSMA has no desire officially, to imply that its members are required to violate federal law; and

WHEREAS, The term 'advise' has been subject to ambiguous interpretation leading to unfortunate, undesirable and divisive controversy diverting attention from vitally important contemporary issues which require the undivided and exclusive concentration of our membership; THEREFORE, BE IT

RESOLVED, That the term 'advise its members not to involve themselves' not be interpreted as a requirement by this association for nonparticipation in PSRO activities: and BE IT FURTHER

RESOLVED, That the terminology of Resolution 23-74 shall not preclude participation by OSMA members in various aspects of PSRO activities in conformance with the law if they so desire.

By official action, the House voted to adopt Amended Resolution No. 21-75.

RESOLUTION NO. 14-75 Exploitation of Physicians

"Subsequently, Resolution No. 14-75, introduced by the Ross County Medical Society and entitled 'Exploitation of Physicians,' was considered. It was felt, in the light of the action on Resolutions 17-75 and 21-75, to be not relevant.

"Mr. Chairman, your Resolutions Committee recommends and I move that Resolution 14-75 be not adopted."

"By official action, the House voted to reject Resolution No. 14-75.

RESOLUTIONS NOS. 15-75 and 16-75

"Next considered were Resolutions Nos. 15-75 and 16-75, both introduced by the Huron County Medical Society, the first entitled 'OSMA Council Action on PSRO' and the second entitled 'To Let Hospitals Implement PSRO.'

"Following lengthy discussion of the previous resolutions, both in open hearing and executive meeting, the Committee felt that neither of these resolutions had merit.

"Therefore, Mr. Chairman, your Resolutions Committee recommends and I move that Resolution 15-75 be <u>not</u> adopted."

"Mr. Chairman, following our consideration of Resolution No. 15-75 the committee recommends and I move that Resolution No. 16-75 be <u>not</u> adopted."

By official action, the House voted to reject both Resolutions Nos. 15-75 and 16-75.

RESOLUTION NO. 18-75 Confidentiality

"The Committee next considered Resolution No. 18-75, introduced by C. G. Madsen, Jr., M.D., member of Lake County Medical Society, entitled 'Confidentiality.'

"The tenor of this resolution is difficult to argue as it concerns a subject we have already treated, which is confidentiality of records and information, and as a solution to this problem, recommends that the OSMA work toward insuring the availability of practicing physicians on a task force concerning confidentiality.

"Mr. Chairman, your Resolutions Committee recommends and I move adoption of Resolution No. 18-75."

AMENDED RESOLUTION NO. 18-75 Confidentiality

WHEREAS, When Vice-President, President Ford chaired the Domestic Council Committee on the Right of Privacy, and that Committee assigned to the Department of Health, Education and Welfare the task of proposing initiatives for assuring confidentiality of health and medical records which are related to Federal Government programs; and

WHEREAS, A task force in the Office of the Assistant Secretary for Health is currently studying this issue with an eye toward recommending steps to apply privacy safeguards to medical record keeping; and

WHEREAS, The inclusion of clinical interests alongside fiscal interests would warrant inclusion on that task force of non-salaried physicians whose primary concern in their daily practices is protection of patients' clinical interests as contrasted to financial interests; THEREFORE, RF IT

RESOLVED, That the House of Delegates of the Ohio State Medical Association instructs its Delegates to the American Medical Association to work toward passage of a resolution to advise President Ford to recommend to the Department of Health, Education and Welfare that the task force include such physicians, these physicians to be from among those whom the American Medical Association may recommend; AND BE IT FURTHER

RESOLVED, THAT THE OHIO STATE MEDICAL AS-SOCIATION REAFFIRMS THE RIGHT OF CONFI-DENTIALITY OF ALL MEDICAL RECORDS.

By official action, the House voted to amend Resolution No. 18-75 as indicated by the additions set forth in capital letters, then adopted it.

RESOLUTIONS NOS. 19-75 and 20-75

"Following our discussions of Resolutions Nos. 14-75, 17-75 and 21-75, the Committee felt those views presented in Resolutions Nos. 19-75 and 20-75, introduced by the Council of the Mahoning County Medical Society, entitled 'Region Six Peer Review Corporation of Akron,' and 'Reaffirmation of OSMA Position on PSRO,' added very little to clear the waters concerning the position of OSMA on PSRO.

"Therefore, Mr. Chairman, your Resolutions Committee recommends and I move that Resolution No. 19-75 be <u>not</u>

"In a like manner, Mr. Chairman, your Resolutions Committee recommends and I move that Resolution No. 20-75 be <u>not</u> adopted."

By official action, the House voted to reject both Resolutions Nos. 19-75 and 20-75.

"Mr. Chairman, that concludes the report of Resolutions Committee No. 1. We would like to express our sincere appreciation to the members of the Association who testified, with great patience, before this Committee. I feel that the members of the Association and the members of the Committee conducted themselves in an exemplary manner and the discussion was both meaningful and relevant at all times.

"I am extremely grateful to the Committee for their perseverance in a long hearing and in the executive session in presenting this report for your consideration.

"We thank our legal counsel, Mr. James Pohlman, and OSMA staff, for their assistance in preparing this report and we especially thank our secretary, Dorothy Wilgus, who sat with us and helped us immensely.

"Mr. Chairman, I respectfully submit and move adoption of the Report of Resolutions Committee No. 1, members of which are: Glenn B. Doan, Highland County; Ernest H. Winterhoff, Clark County; Benjamin H. Reed, Fulton County; Lawrence J. McCormack, Cuyahoga County; Rocco M. Antenucci, Summit County; Philip T. Doughten, Tuscarawas County; John F. Kroner, Athens County; A. Burton Payne, Lawrence County; James E. Bames, Franklin County; A Burney Huff, Wayne County; David A. Barr, Allen County, Chairman."

The report of Resolutions Committee No. 1, as a whole, as amended, was approved by the House.

Report of Resolutions Committee No. 2

Dr. Robert B. Elliott, Hardin County, reported for Resolutions Committee No. 2, of which he was chairman. The report read as follows:

"Mister President and Members of the House of Delegates:

"Resoultions Committee No. 2 met in open session on Monday, May 12, 1975, and heard testimony relating to Resolutions No. 22-75 through No. 34-75 and Emergency Resolution No. 50-75.

RESOLUTION NO. 22-75 Third Party Carriers

"The Committee heard testimony from a number of physicians in regard to problems that have arisen in relationship to third party carriers, physicians, and other health care providers. After due consideration, the Committee offers the following substitute resolution:

SUBSTITUTE RESOLUTION NO. 22-75

- WHEREAS, Certain third party carriers have shown marked deviation in paying health care providers and/or patients for services; and
- WHEREAS, Some third party carriers have informed patients that they need not pay the provider in full for services rendered even though the provider has not signed an agreement with the third party carrier; THEREFORE BE IT
- RESOLVED, That the insurance committee of OSMA investigate inequities in payments made to health care providers and send a report to the OSMA Council; and BE IT FIRTHER
- RESOLVED, That the Ohio State Medical Association reaffirm its opposition to hold harmless clauses in contracts between insurance companies and patients.
- "Mr. President, I move the adoption of Substitute Resolution No. 22-75."
- By official action, the House voted to adopt Substitute Resolution No. 22-75.

RESOLUTION NO. 23-75 AMA Fiscal Responsibility

"The Committee heard discussion regarding the financial plight of the AMA and voted to amend Resolution No. 23-75 as follows:

AMENDED RESOLUTION NO. 23-75

- WHEREAS, Information regarding the financial difficulties currently being experienced by the AMA has been extensively reported to the membership, together with recommendations for remedial action; and
- WHEREAS, A recent assessment of all AMA members was approved by the House of Delegates at the Clinical Meeting in Portland; and
- WHEREAS, A dues increase will be considered by the House of Delegates at the annual meeting of the AMA in Atlantic City; THEREFORE BE IT
- RESOLVED, That the OSMA House of Delegates communicate commendations to the present Board of Trustees of the AMA for their appropriate efforts to curtail expenditures where possible; (without affecting the over all effectiveness of the Association); and BE IT FURTHER HOWEVER, BE IT FURTHER

- RESOLVED, That the OSMA encourage the Trustees of the AMA to further decrease expenditures where possible until the budget, once again, is "in balance."
- RESOLVED, THAT THE OVERALL EFFECTIVENESS OF THE ASSOCIATION MUST BE MAINTAINED FOR THE BENEFIT OF EACH OF OUR MEMBERS; AND, THEREFORE BE IT
- RESOLVED, THAT THE HOUSE OF DELEGATES OF THE AMA BE REQUESTED TO CONVEY TO THE MEMBERSHIP THE NECESSITY FOR THEIR CONTINUED INDIVIDUAL FINANCIAL SUPPORT.
- "Mr. President, I move the adoption of Amended Resolution No. 23-75."
- By official action, the House voted to amend Amended Resolution No. 23-75 as indicated by the strike-out deletions, and by the additions set forth in capital letters, then adopted it.

RESOLUTION NO. 24-75 Continuing Medical Education

"The Committee heard testimony in regard to the entire question of continuing medical education. After much debate, open hearings, and consultation with the OSMA Staff, the Committee proposes the following substitute resolution:

SUBSTITUTE RESOLUTION NO. 24-75

- WHEREAS, The Ohio State Medical Association is to be complimented on its efforts in behalf of a formal program for Continuing Medical Education; and
- WHEREAS, The Medical Profession has always encouraged continuing education and study from graduation to retirement: and
- WHEREAS, The devotion of the Medical Profession to continuing medical education has and will continue regardless of pressures that might come about through the legislative process; and
- WHEREAS, The medical profession believes that one of the ways to assure a physician's competence is to insist that he maintain a program of continuous medical education for as long as he shall practice; THEREFORE BE IT
- RESOLVED, That the House of Delegates of the Ohio State
 Medical Association require that satisfactory evidence of
 continuing medical education be a condition for membership in OSMA; and BE-IT-FURTHER
- RESOLVED, That the Committee on Medical Education of OSMA study this proposal and recommend to the House of Delegates at the next session which specific requirements shall constitute satisfactory evidence of continuing medical education.
- RESOLVED, THAT THE HOUSE OF DELEGATES OF THE OSMA BELIEVES THAT AN ACCEPTABLE SYS-TEM OF CONTINUING MEDICAL EDUCATION SHOULD BE DEVELOPED FOR MEMBERSHIP IN OSMA, AND BE IT FURTHER

RESOLVED, THAT THE COMMISSION ON MEDICAL EDUCATION OF OSMA DEVELOP REQUIREMENTS AND RECOMMEND TO THE HOUSE OF DELEGATES AT THE NEXT SESSION OF THE HOUSE WHICH SPECIFIC REQUIREMENTS SHALL CONSTITUTE SATISFACTORY EVIDENCE OF CONTINUING MEDICAL EDUCATION PARTICIPATION, AND BE IT FURTHER

RESOLVED, THAT THE PROGRAM, AS DEVELOPED BY THE COMMISSION ON MEDICAL EDUCATION BE SUBMITTED IN AMPLE TIME TO THE COMMITTEE ON CONSTITUTION AND BYLAWS FOR APPROPRIATE CHANGES, IF NECESSARY, IN TIME FOR FINAL ACTION BY THIS HOUSE OF DELEGATES AT THE 1976 ANNUAL MEETING.

"Mr. President, I move the adoption of Substitute Resolution No. 24-75."

By official action, the House voted to amend Substitute Resolution No. 24-75 as indicated by the strike-out deletions, and by the additions set forth in capital letters, then adopted it.

EMERGENCY RESOLUTION NO. 50-75 H. B. 682

"The Committee heard much open testimony on Emergency Resolution No. 50-75 and then also heard considerable testimony from the OSMA Staff and Legal Counsel regarding the legislative implications of this resolution. The Committee offers the following substitute emergency resolution:

SUBSTITUTE EMERGENCY RESOLUTION NO. 50-75

WHEREAS, Recognizing that certain changes in the Ohio Medical Practice Act may be necessary; and

WHEREAS, It is believed that all of the necessary changes should not be associated with an omnibus professional liability act; THEREFORE BE IT

RESOLVED, That The Council of the Ohio State Medical Association review the Ohio Medical Practice Act to determine if any changes are necessary.

"There was one dissenting vote. This Committee member felt that revision of the Ohio Medical Practice Act should be totally divorced from the solution to the professional liability dilemma.

"Mr. President, I move the adoption of this Substitute

Emergency Resolution No. 50-75.'

A minority report was then introduced by James Anderson, Delegate from Mahoning County, and a member of Resolutions Committee No. 2. After a lengthy discussion, the minority report was defeated.

By official action, the House voted to adopt Substitute Emergency Resolution No. 50-75.

RESOLUTION NO. 25-75 Catholic Hospital Association

"The Committee next heard testimony is regard to Resolution No. 25-75, and after due consideration, unanimously recommended the adoption and, Mr. President, I so move."

The resolution reads as follows:

RESOLUTION NO. 25-75 Catholic Hospital Association

WHEREAS, There has been an increasing tendency on the part of hospital administrators and Boards of Trustees of hospitals to so structure hospital Constitutions and Bylaws that physician members of medical staff organizations are placed in an employee relationship to the administration and Board of Trustees in the rendering of health care, rather than as independent practitioners with prime responsibility and relationship to the patient; and

WHEREAS, Such relationships of physician to hospital administrator interfere with proper involvement of physicians in the policy and decision making processes of the hospital and with the proper care of their patients; and

WHEREAS, The Catholic Hospital Association has recently issued a set of guidelines which incorporate these theories of hospital organization in their recommendations to their member hospitals to the potential detriment of patient care and intra-hospital relationships of physician, administrator, and Boards of Trustees; THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association indicate to the Catholic Hospital Association their concern with the possible detrimental effects of these guidelines on patient care and earnestly suggest reevaluation of these guidelines with a view to revision, so as to confirm the status of physician members of the medical staff organization as independent practitioners in their relationships to their patients and to establish direct lines of communication between physicians in the policy and decision making processes of the institution; and BE IT FURTHER

RESOLVED, That copies of this resolution be forwarded to the Catholic Hospital Association and that this resolution be brought to the annual meeting of the American Medical Association as a resolution by our delegation of the Ohio State Medical Association.

By official action, the House voted to adopt Resolution No. 25-75.

RESOLUTION NO. 26-75 Abortion Advertising

"The Committee then discussed Resolution No. 26-75 and heard considerable testimony in regard to abortion clinics and their advertising practices within Cuyahoga County. There has been considerable discussion and delib-

eration within Cuyahoga County and it is because of this that the resolution was submitted. It was the unanimous opinion of the Committee that the participation by a physician in an organization which directly or indirectly solicits patients for abortion or any other medical services constitutes a breach of medical ethics. According to the bylaws of the Association currently in effect (Chapter 7, Section I), questions of ethics shall be referred to the Council without discussion, and, Mr. President, I so move."

RESOLUTION NO. 26-75 Abortion Advertising

- WHEREAS, Abortion must by law, be performed by a licensed Doctor of Medicine or Doctor of Osteopathy; and
- WHEREAS, Abortion as with any other medical procedure, must be performed in accord with the highest standards of medical practice; and
- WHEREAS, Abortion Clinics in our state have been indulging in newspaper, radio, and television advertising of a medical service: and THEREFORE. BE IT
- RESOLVED, That the Ohio State Medical Association declare that the participation by a physician in an organization which engages in the direct or indirect advertising of abortion services or permits such organization to sell or offer for sale the physician's professional services is unethical.

The House voted to table Resolution No. 26-75 until after action on Resolution No. 48-75, "Hearing of Resolutions Involving Ethics." It was then removed from the table and by official action, the House voted to adopt Resolution No. 26-75.

RESOLUTION NO. 27-75 Special Committee to Analyze Published Health Statistics for Dissemination to the Physicians

"The Committee then discussed Resolution No. 27-75 and after hearing of the problem as related by the Academy of Medicine of Cincinnati recommended the following amended resolution:

AMENDED RESOLUTION NO. 27-75

- WHEREAS, Statistics on the delivery of health care are presently being disseminated by local, state, and federal agencies; and
- WHEREAS, The interpretation of said statistics by government and local agencies is questionable; and
- WHEREAS, Some of these statistics have been improperly collected and published; and have been accepted by the media without verification; THEREFORE BE IT AND
- RESOLVED, That the Ohio State Medical Association analyze all pertinent published statistics on the delivery of health care for an accurate and authentic interpretation; and BE IT FURTHER

- RESOLVED, That the Ohio State Medical Association publish these accurately interpreted statistics for the physicians of the State of Ohio
- WHEREAS, THE AMA ALREADY AUTHENTICATES AND PUBLISHES THE NECESSARY DATA EACH YEAR IN TWO VOLUMES ENTITLED 'SOCIO-ECONOMIC ISSUES OF HEALTH' AND 'PROFILE OF MEDICAL PRACTICE'; THEREFORE BE IT
- RESOLVED, THAT COUNCIL OF OSMA ARRANGE WITH AMA FOR DISTRIBUTION OF THESE TWO PUBLICATIONS TO APPROPRIATE LOCAL AND STATE AGENCIES AND CONCERNED PHYSICIANS OF THE STATE OF OHIO

"Mr. President, I move the adoption of Amended Resolution No. 27-75"

By official action, the House voted to amend Amended Resolution No. 27-75 as indicated by the strike-out deletions, and by the additions set forth in capital letters, then adopted it.

RESOLUTION NO. 28-75 Development of Outreach Program for Heart Disease and Stroke and

RESOLUTION NO. 30-75 Earlier Detection of Breast Cancer

"The Committee next considered Resolution No. 28-75 and Resolution No. 30-75 together and realized that a central theme existed in that both were directing attention to certain specific disease entities and the preventive and early detection aspects thereof. Realizing that these programs deserve further study and cost evaluation, the Committee recommends that these two resolutions be referred to The Council of OSMA for reference to the appropriate OSMA committees for review and subsequent report, and, Mr. President, I so move." The resolutions read as follows:

RESOLUTION NO. 28-75 Development of Outreach Program for Heart Disease and Stroke

- WHEREAS, Heart disease and stroke claim many lives and inflict great morbidity and cost on the entire population; and
- WHEREAS, the Ohio State Medical Association is an organization of physicians which specializes in the diagnosis and treatment of stroke as well as education of the population in medical matters; THEREFORE BE IT
- RESOLVED, That the Ohio State Medical Association develop a program to educate the population at large and primary care physicians in the State of Ohio concerning the prevention of, and diagnosis and treatment of all aspects of cardiovascular disease and stroke.

RESOLUTION NO. 30-75 Earlier Detection of Breast Cancer

WHEREAS, The persistent high mortality rate due to cancer of the breast, and the observation that survival of patients with this disease is closely dependent on early detection, as well as the presence or absence of lymph node metastates at the time of inital treatment, the earliest detection possibly is mandatory; and

WHEREAS, Recent controlled diagnostic trials have shown this to be true; and

WHEREAS, Mammography is readily available in practically all communities of Ohio THEREFORE, BE IT

RESOLVED, That mammographic examinations be advised as an adjunct to clinical and self examinations in all patients of high risk, but particularly in:

1. Patients having a previous cancer of the breast.

2. Patients with a positive family history of breast cancer.

3. Nulliparous women over 35 years of age; and BE IT FURTHER

RESOLVED, That these examinations occur at intervals of one to three years (or sooner) depending on the observation of the patient's physician; and BE IT FURTHER

RESOLVED, That mammography be used as an adjunct clinical modality, under the direction of a radiologist, but that it should not replace or preclude physical examination or breast self examination.

By official action, the House voted to adopt the recommendation of the Committee.

RESOLUTION NO. 29-75 Legislation to Protect Supply of a Life Saving Drug

"Going on to Resolution No. 29-75 and after discussion of the reported shortage of heparin, the Committee recommends adoption of the following substitute resolution:

SUBSTITUTE RESOLUTION NO. 29-75

WHEREAS, Heparin is a life-saving drug; and

WHEREAS, The supply of this drug and its availability to physicians in the State of Ohio has been reported to be at a dangerously low level; THEREFORE BE IT

RESOLVED, That the Ohio State Medical Association acknowledge the shortage of heparin, a life-saving drug, and inform appropriate agencies of our concern. THE SHORTAGE OF THIS DRUG AND OTHER IMPORTANT DRUGS TO PHYSICIANS TO ASSURE THEIR FUTURE SUPPLY.

"Mr. President, I so move the adoption of Substitute Resolution No. 29-75."

By official action, the House voted to amend Substitute Resolution No. 29-75, as indicated by the strike-out deletions, and by the additions set forth in capital letters, then adopted it.

RESOLUTION NO. 31-75 Information-Medical Advances Institute

"The committee then considered Resolution No. 31-75 and after deliberation recommends the adoption of the following substitute resolution:

AMENDED SUBSTITUTE RESOLUTION NO. 31-75

WHEREAS, Allegedly there is to be a sale of the peer review system of Medical Advances Institute; and

WHEREAS, Some members of the Board of Trustees of Medical Advances Institute are also officers of the Ohio State Medical Association; and

WHEREAS, Medical Advances Institute was formed by initial endorsement of the House of Delegates of the Ohio State Medical Association: and

WHEREAS, Medical Advances Institute has, in part, been funded, at least in kind, by the Ohio State Medical Association; THEREFORE BE IT

RESOLVED, That The Council of the Ohio State Medical Association be provided detailed financial statements of Medical Advances Institute in accordance with standard accounting techniques on a periodic basis; AND BE IT FURTHER

RESOLVED, THAT THE COUNCIL OF THE OHIO STATE MEDICAL ASSOCIATION URGE MEDICAL ADVANCES INSTITUTE TO DISSEMINATE INFORMATION CONCERNING MATERIAL AVAILABLE FOR LOCAL PEER REVIEW COMMITTEES IN ORDER THAT THE VALUABLE WORK BY MANY PHYSICIANS OF THIS SOCIETY IN CONSTRUCTING CRITERIA AND STANDARDS NOT BE LOST.

"Mr. President, I so move the adoption of Substitute Resolution No. 31-75."

By official action, the House voted to amend Substitute Resolution No. 31-75, as indicated by the strike-out deletions, and by the additions set forth in capital letters, then adopted it.

RESOLUTION NO. 32-75 Surveys

"The Committee, at this time, considered Resolution No. 32-75 and felt that the resolution has some admirable qualities, but that it needed to be changed in some respects. We therefore submit the following substitute resolution:

SUBSTITUTE RESOLUTION NO. 32-75

RESOLVED, That the Ohio State Medical Association, after consultation with AMA, design a model patient opinion poll to be published in the Ohio State Medical Journal for members to submit to their patients as they desire. The results may be submitted to the Ohio State Medical Association Headquarters for tabulation at its discretion.

"Mr. President, I move the adoption of Substitute Resolution No. 32-75."

By official action, the House voted to adopt Substitute: Resolution No. 32-75.

RESOLUTION NO. 33-75 Minutes of OSMA Council Meetings

"The Committee then considered Resolution No. 33-75 and after considerable debate felt that the minutes of the

Council meetings had been made available in the Ohio State Medical Journal and could be obtained from the Councilor or the Headquarters if the individual desired the same. We recommend that Resolution No. 33-75 be not adopted and. Mr. President, I so move."

By official action, the House voted to reject Resolution No.

33-75.

RESOLUTION NO. 34-75 Itemizations — Costs and Services Rendered

"Finally, the Committee considered Resolution No. 34-75. After considerable debate, it was the feeling of the Committee that the resolution as submitted was not acceptable. We recommend that the resolution be not adopted and. Mr. President, I so move."

By official action, the House voted to reject Resolution No.

34-75.

"The Committee wishes to thank all those who appeared and gave testimony and we thank the OSMA Staff and, in particular, Vickey McVay for her diligence. I would like to thank the members of the Committee for their dedication and fortitude and for a job well done. Mr. President, I move adoption of the Report of Resolutions Committee No. 2.

"Respectfully submitted, Jerry D. Hammond, Butler County; A. Robert Davies, Miami County; Willis L. Damschroder, Sandusky County; Theodore J. Castele, Cuyahoga County; J. James Anderson, Mahoning County; Robert R. Johnson, Coshocton County; W. B. Devine, Muskingum County; Roger P. Daniels, Meigs County; Henry Lapp, Knox County; S. Baird Pfahl, Jr., Erie County; Robert B. Elliott, Hardin County, Chairman."

The report of Resolutions Committee No. 2, as a whole,

as amended, was approved by the House.

Report of Resolutions Committee No. 3

Dr. J. Hutchison Williams, Franklin County, reported for Resolutions Committee No. 3, of which he was chairman. The report read as follows:

"Mr. President and Members of the House of Delegates:

"Resolutions Committee No. 3 was assigned a total of 15 resolutions, three of which were sufficiently related, No. 37, 38, and 39 that they were considered together. Three and one half hours of open hearing elicited a great deal of valuable information and opinion for which the Committee is genuinely grateful to the participating membership."

RESOLUTION NO. 35-75 Combined Annual Dues and Assessments

"Resolution No. 35-75 was considered by the Committee to concern a matter which is properly a function of the House of Delegates (Bylaws of the Constitution Chapter 2, Section 1.) The concerns expressed in the resolution were

noted to be adequately covered in Resolution No. 44-75 which was adopted by the Committee during the same session. It is therefore the unanimous recommendation of this Committee that Resolution No. 35-75 be not adopted, and, Mr. President, I so move."

By official action, the House voted to reject Resolution No. 35-75

RESOLUTION NO. 36-75 Semi-Annual Meeting of OSMA House of Delegates

"Resolution No. 36-75 was heard and discussed at length. Much testimony was heard in favor of the concept and the issues with lack of data as to the additional benefits derived by those state societies which have undertaken semi-annual meetings, precluded a final recommendation at this time.

"It was the unanimous opinion of the Committee that further study with more data was essential to a final decision in this matter. The Committee recommends that this resolution be referred to the Council, for reference to an appropriate Committee for further study to culminate in a proper resolution to be considered by the House of Delegates, and, Mr. President. I so move."

By official action, the House voted to adopt the recommendation of the Committee.

RESOLUTION NO. 37-75 Election of Councilors to OSMA

"Resolutions No. 37-75, 38-75 and 39-75, dealing with the method of election of councilors to the OSMA, were all addressed to similar concerns and were therefore heard and deliberated together. At bottom the issue seemed to be a potential loss of control by a given district caucus over the nomination of its own councilor. In recognition of this concern, but being also fully cognizant of the importance of the concept of possible nomination from the floor of the House in session, the following substitute resolution was promulgated:

SUBSTITUTE RESOLUTION NO. 37-75 Nomination of District Councilors

WHEREAS, The Committee on nominations of the House of Delegates of the Ohio State Medical Association is charged with selecting the nominee(s) for councilor; and

WHEREAS, The only present restriction regarding nominee(s) for councilor is that the nominee must reside in the councilor district for which he is nominated; and

WHEREAS, Such method of selection of nominee(s) and election of councilors could result in election of a councilor not representative of the majority membership of his district: THEREFORE, BE IT

RESOLVED, That nominations for the office of councilor shall be made from the floor of the House of Delegates; provided, however, that only those candidates may be

nominated whose names have been filed with the Executive Director at the time and in the manner hereinafter provided, unless compliance with such requirements shall be waived as hereinafter provided; that the name of a candidate for the office of councilor must be filed by the caucus of that district's delegates with the Executive Director of the Association prior to the opening of the first session of the House of Delegates in Annual Meeting, and that no nomination for councilor may be presented at any meeting unless the foregoing has been complied with or unless such compliance shall have been waived or dispensed with by a vote of at least two-thirds (2/3rds) of the delegates present at the opening session of such meeting, and BE IT FURTHER

RESOLVED, That a copy of this resolution be referred to the special committee on Constitution and Bylaws for preparation of an appropriate resolution containing specific language for introduction at the next meeting of the House of Delegates.

"Mr. President, I move adoption of Substitute Resolution No. 37-75."

By official action, the House voted to adopt Substitute Resolution No. 37-75.

RESOLUTION NO. 40-75 Creating a Twelfth Councilor District

"Fully an hour's testimony was heard concerning the advisability of creating a new Twelfth District of the Ohio State Medical Association. The arguments were many and sound on both sides of the issue. Emotions were, for the most part, well restrained, although the intensity of the issue is well known and was apparent.

"The Committee concluded that the acceptance of a resolution creating an additional councilor district would set a dangerous precedent for solution of any conflict in a particular district in the future.

"The Committee concluded further that there was sufficient merit in the Summit County position as to suggest that there could possibly be inequities in other districts as well, even though obviously less apparent.

"The Committee heard testimony that it had been several years since an in-depth study of districts was carried out and it was cognizant of the fact that changes in districts were recommended but not approved by the House of Delegates at that time.

"The question arose as to whether one or more other redistricting considerations should also be evaluated.

"For all the above reasons the Committee agreed unanimously to the following substitute resolution:

AMENDED SUBSTITUTE RESOLUTION NO. 40-75

RESOLVED, That the Council of the Ohio State Medical Association appoint a Committee to again study the present Councilor Districts and to recommend to the House of Delegates at its next regular meeting such changes as are concluded to be indicated.

BE IT FURTHER RESOLVED, That due to the urgency of the immediate situation, the Committee be specifically charged with finding an equitable solution to the aforementioned problem in the Sixth District. HOUSE OF DELEGATES WITH THE AUTHORITY GRANTED TO IT BY SECTION 6, CHAPTER 4 OF THE BYLAWS OF THE OHIO STATE MEDICAL ASSOCIATION, IMMEDIATELY ESTABLISH PORTAGE AND SUMMIT COUNTY MEDICAL SOCIETIES AS THE TWELFTH COUNCILOR DISTRICT OF OHIO STATE MEDICAL ASSOCIATION, REMOVING THEM FROM THE SIXTH COUNCILOR DISTRICT, OSMA; AND BE IT FURTHER

RESOLVED, THAT THE PRESIDENT OF OSMA IM-MEDIATELY APPOINT A COUNCILOR FROM THIS NEW DISTRICT TO SERVE UNTIL THE 1977 AN-NUAL MEETING WHEN HE OR SHE WILL STAND FOR ELECTION WITH REPRESENTATIVES OF THE OTHER EVEN-NUMBERED OSMA COUNCILOR DISTRICTS.

"Mr. President, I move adoption of Substitute Resolution No. 40-75."

By official action, the House voted to amend Substitute Resolution No. 40-75 as indicated by the strike-out deletions, and by the additions set forth in capital letters, then adopted it.

RESOLUTION NO. 41-75 Appointment of Members to Resolutions Committee

"The Committee fully appreciates the good intentions of Resolution No. 41-75 but it was the consensus that the necessity for placing trust in our duly elected officers transcends these considerations. The President must have the right to choose his committee membership by finally selecting those whom he recognizes to be best suited by way of personal expertise, from the list of those suggested by his councilors.

"It is therefore the unanimous recommendation of this Committee that Resolution No. 41-75 be <u>not</u> adopted, and, Mr. President, I so move."

By official action, the House voted to reject Resolution No. 41-75.

RESOLUTION NO. 42-75 Voluntary Membership in OSMA

"The Committee found Resolution No. 42-75 to be in conflict with the purpose clause of the Constitution of the Ohio State Medical Association which is composed of component societies which, in turn, receive their charters from the OSMA. The Committee further noted that most local societies would likely be reduced to impotence if each were to go it alone.

"The Committee, therefore, voted unanimously that Resolution No. 42-75 be <u>not</u> adopted, and, Mr. President, I so move."

By official action, the House voted to reject Resolution No. 42-75.

RESOLUTION NO. 43-75 Student Membership

"The Committee found this Resolution No. 43-75 proper and acceptable as submitted and voted unanimously that it be adopted and, Mr. President, I so move."

The resolution reads as follows:

RESOLUTION NO. 43-75 Student Membership

RESOLVED, That Article III, Section 1, of the Constitution be amended by adding the following:

'(8) Student Members'

RESOLVED, That Chapter 1, Section 2, of the Bylaws be amended by adding the following:

'(i) Student members. Student Members of this Association shall comprise those students in good standing who are pursuing the diploma of Doctor of Medicine in an approved medical college or institution in the State of Ohio.'

RESOLVED, That Chapter 1, Section 3, of the Bylaws be amended by adding the following in paragraph 1, line 2, after the word 'honorary:'

'affiliate or student'

By official action, the House voted by a 2/3rds majority to adopt Resolution No. 43-75.

RESOLUTION NO. 44-75 Fiscal Notes

"The Committee not only found Resolution No. 44-75 to be highly acceptable, but, in addition, would call attention to the benefit which might accrue were such a policy adopted by our state and federal governmental legislative bodies.

"The Committee voted unanimously that Resolution No. 44-75 be adopted, and, Mr. President, I so move."

The resolution reads as follows:

RESOLUTION NO. 44-75 Fiscal Notes

RESOLVED, That Chapter 4, Section 8 of the Bylaws be amended to read as follows:

Section 8. Resolutions. Every resolution to be presented to the House of Delegates for action shall be filed with the Executive Director of the Association at least sixty (60) days prior to the first day of the meeting at which action on such resolution is proposed to be taken; and promptly upon the filing of any such resolution the Executive Director shall prepare and transmit a copy thereof to each member of the House of Delegates.

'Each resolution which, if adopted, would require expenditure of funds by the Association, shall have attached, a statement of the amount of the estimated annual expenditure.' No resolution may be presented or

introduced at any meeting of the House of Delegates unless the foregoing requirements for filing and transmittal shall have been complied with or unless such compliance shall have been waived by a Special Committee on Emergency Resolutions named to decide whether late submission was justified. This special committee shall consist of the chairmen of the several resolution committees. If a majority of the members of the Special Committee on Emergency Resolutions vote favorably for waiving the filing and transmittal requirement, then such resolution shall be presented to the House of Delegates at its opening session. All resolutions presented subsequent to the 60-day filing date prior to the opening session of the House of Delegates shall be submitted by their sponsors to the committee no less than 12 hours prior to the opening session of the House of Delegates.

The Executive Director shall cause to be published in **The Journal** in advance of such meeting of the House of Delegates such resolutions as the President or the Council may designate.

No consideration may be given, or any action taken, by the Committee on Resolutions or by the House of Delegates, with respect to any resolution unless such resolution shall have been presented or introduced at the opening session of the meeting of the House of Delegates: provided, however, that a resolution dealing with an event or development occurring too late to permit the introduction of any such resolution at the opening session may be introduced at a later session with the consent of at least four-fifths (4/5) of the delegates present; and upon its introduction, such resolution shall be referred to the Committee on Resolutions for consideration and report: and, provided further, that the Committee on Resolutions shall have the right to amend any resolution presented or introduced, or to draft a composite or substitute resolution embracing the same subject matter as that contained in a resolution or resolutions presented or introduced, and to submit such amended, composite or substitute resolution for adoption by the House of Delegates, and the House of Delegates shall have the right to adopt any such amended, composite or substitute resolution.

By official action, the House voted by a 2/3rds majority to adopt Resolution No. 44-75

RESOLUTION NO. 45-75 Report on Professionalism

"Being unable to clarify Resolution No. 10-74 with no further information concerning its scope, purpose, or intent, the Committee found no basis upon which to further pursue the previously passed Resolution No. 10-74. It is the unanimous opinion of the Committee that the Report on Professionalism be accepted, but that Resolution No. 10-74 be repealed and that the matter be dropped, and, Mr. President. I so move."

By official action, the House voted to adopt the Committee's recommendation on Resolution No. 45-75.

RESOLUTION NO. 46-75 Publication of Budget

"The Committee found this Resolution No. 46-75 proper and acceptable as submitted and voted unanimously that it be adopted and, Mr. President, I so move."

The resolution reads as follows:

RESOLUTION NO. 46-75 Publication of Budget

RESOLVED, That Chapter 7, Section 5, of the Bylaws be amended to read as follows:

'An Auditing and Appropriations Committee consisting of three members of the Council shall be appointed by the President, with the consent of the Council, to serve for one year. This Committee shall prescribe the method of accounting and shall audit any and all accounts of this Association. It shall prepare and present annually to the Council a budget providing for the necessary expenses of this Association. The budget, after approval by the Council, shall be published and distributed to the delegates and alternate delegates at least 90 days prior to the Annual Meeting. Any surplus or balance of funds for a given year shall revert to the general fund. The President, the President-Elect, the Immediate Past President and the Secretary-Treasurer shall be ex-officio members of such Committee with full voting rights.'

By official action, the House voted by a 2/3rds majority to adopt Resolution No. 46-75.

RESOLUTION NO. 47-75 Affiliate Members

"The Committee found this Resolution No. 47-75 proper and acceptable as submitted and voted unanimously that it be adopted and, Mr. President, I so move."

The resolution reads as follows:

RESOLUTION NO. 47-75 Affiliate Members

RESOLVED, That Article III, Section 1, of the Constitution be amended by adding the following:

'(7) Affiliate Members;' and

RESOLVED, That Chapter 1, Section 2, of the Bylaws be amended by adding the following:

'(h) Affiliate Members, Executives of the Ohio State Medical Association, county medical societies, and other medical organizations and specialty societies in Ohio with three years or more experience in the sponsoring organization are eligible for Affiliate Membership in the Ohio State Medical Association. Such Affiliate Membership shall be at the pleasure of the Council. An Affiliate Member shall pay no dues or assessments.'

By official action, the House voted by a 2/3rds majority to adopt Resolution No. 47-75.

RESOLUTION NO. 48-75 Hearing of Resolutions Involving Ethics

"The Committee found this Resolution No. 48-75 proper and acceptable as submitted and voted unanimously that it be adopted and, Mr. President, I so move."

Resolution No. 48-75 reads as follows:

RESOLUTION NO. 48-75 Hearing of Resolutions Involving Ethics

RESOLVED, That Chapter 7, Section 1, Paragraph 4, of the Bylaws be amended to read as follows:

'The Council shall be the board of censors of this Association, considering all questions involving the rights and standing of members, whether in relation to other members, to the component societies, or to this Association. All questions of an ethical nature brought before the House of Delegates involving the professional relations of individual physicians or groups of physicians shall be referred to the Council without discussion. The Council shall have full power and authority to hear and decide all questions of discipline affecting the conduct of the members of this Association or the conduct of a component society. Its decisions in all cases, including questions regarding the right of membership in this Association, shall be final;' and

RESOLVED, That Chapter 4, Section 4, Paragraph 1 of the Bylaws be amended to read as follows:

'Section 4. Committees of the House of Delegates. For the purpose of expediting proceedings the President shall appoint from the roster of delegates the following reference committees: Committee on President's Address; Committees on Resolutions, to which shall be referred all resolutions (except those of an ethical nature involving the professional relations of individual physicians or groups of physicians); Committee on Credentials; and other committees considered necessary by the President.'

By official action, the House voted by a 2/3rds majority to adopt Resolution No. 48-75.

RESOLUTION NO. 49-75 Abortion

"The Committee recognizes that abortion is a matter for decision based upon the individual conscience of the patient and her physician. The matter has been previously discussed and so adjudged by the House of Delegates of the OSMA. The Committee voted unanimously that Resolution No. 49-75 be <u>not</u> adopted, and, Mr. President, I so move."

By official action, the House voted to reject Resolution No. 49-75.

"Mr. President, I respectfully submit and move adoption of the Report of Resolutions Committee No. 3, members of which are: Eugene J. Burns, Hamilton County; R. Alan Baker, Montgomery County; James Otis, Mercer County; Thomas F. Moriarty, Henry County; Wesley J. Pignolet, Lake County; Edward E. Grable, Stark County; Donald Piatt, Monroe County; Robert Ringer, Guernsey County; Kenneth E. Wilkinson, Pike County; Harold F. Mills, Richland County; J. Hutchison Williams, Franklin County, Chairman."

The report of Resolutions Committee No. 3, as a whole, as amended, was approved by the House.

OSMA Building

Dr. A. Burney Huff, Delegate, Wayne County, asked for the floor. He called attention to the new OSMA Headquarters' Office and to the successful Open House, held May 12, and moved for a vote of the House to express thanks to the men who made these a reality. The motion was duly seconded and adopted by a standing vote.

Appreciation Expressed

Dr. Henry expressed his thanks to the OSMA staff, and the Delegates rose in a vote of appreciation to the staff.

Inaugural Ceremony

Dr. Clarke administered the presidential oath of office to Dr. Maurice F. Lieber and Dr. Henry, retiring President, presented to Dr. Lieber the official gavel and the President's Medallion. Mrs. Henry was then introduced and was escorted to the podium by Dr. James C. McLarnan. Dr. Clarke then presented President's Medallion pins to Dr. and Mrs. Henry, and the certificate of honor to Dr. Henry. Dr. Lieber presented to Dr. Henry the Past President's Button.

Remarks by Dr. Lieber

Dr. Lieber addressed the House of Delegates with regard to the unity of purpose and the ongoing work of the Association.

Councilor Appointed

Dr. Lieber appointed Dr. William Domer, Jr., of Akron, as the Councilor of the newly established Twelfth District.

Committees Named

Dr. Lieber presented the following standing committee appointments and they were officially approved by the House of Delegates:

Committee on Education — Dr. John G. Sholl, Cleveland, reappointed chairman for ensuing year; Dr. Clyde W. Muter, Warren, reappointed member for an unexpired term ending in 1976; Dr. Carl E. Spragg, New Concord, appointed member for a term of five years.

Committee on Judicial and Professional Relations—Dr. Homer A. Anderson, Columbus, reappointed chairman for ensuing year and reappointed member for a term of five years.

Committee on Membership and Planning — Dr. William R. Schultz, Wooster, reappointed chairman for ensuing year; Dr. Richard L. Meiling, Columbus, reappointed member for a five year term.

Committee on Public Relations — Dr. Luther W. High, Millersburg, reappointed chairman for ensuing year and reappointed member for a term of five years.

Committee on Scientific Work — Dr. John E. Albers, Cincinnati, appointed chairman for ensuing year; Dr. Vincent T. LaMaida, Cleveland, reappointed member for a term of five years; Dr. Jack Schreiber, Canfield, reappointed member for a term of five years; Dr. James C. McLarnan, Mt. Vernon, appointed member for unexpired term ending in 1978.

Lieber Family Introduced

Before adjourning, Dr. Lieber's wife and two daughters were introduced and received the plaudits of the House of Delegates.

There being no further business, the House of Delegates then adjourned sine die.

ATTEST: Hart F. Page Executive Director

proceedings of the council

THE COUNCIL of the Ohio State Medical Association met at 8:30 a.m., May 15, 1975, at the Sheraton-Columbus Hotel. All members of the Council were present.

Staff members present were Messrs. Page, Edgar, Gillen, Campbell, Clinger, Rader, Houser, Mulgrew, Holcomb, Freeman, Mrs. Wisse, Mrs. Dodson, Ms. Doll and Mrs. Tanner.

Legal Counsel was present and Dr. Richard L. Meiling represented Ohio's AMA Delegation.

On a motion by Dr. Hogg, seconded by Dr. Smithson, the Council appointed Dr. William Dorner, Jr., Akron, as Twelfth District Councilor.

Dr. Lieber then introduced newly elected and reelected Councilors as follows:

Second District—W. J. Lewis, M.D., Dayton Fourth District—C. Douglass Ford, M.D., Toledo Sixth District—C. Edward Pichette, M.D., Youngs-

Eighth District—Richard E. Hartle, M.D., Lancaster Tenth District—J. Hutchison Williams, M.D., Co-

Twelfth District-William Dorner, Jr., M.D., Akron

Dr. Lieber then congratulated Mrs. Gail Dodson on the success of the 1975 Annual Meeting.

Special Committee appointments for 1975-1976 were

ratified (Morgan-Hogg).

Dr. Lieber reinstituted the following task force to make interim decisions between Council meetings with regard to the professional liability crisis program of OSMA.

James L. Henry, M.D., Chairman Maurice F. Lieber, M.D. George N. Bates, M.D. William M. Wells, M.D.

Changes in the front cover of The Ohio State Medical Journal, on a trial basis, were approved.

Minutes of a meeting of the Committee on Laboratory Medicine held May 13, 1975 were presented by Mr. Rader and were approved.

Future Council meeting dates were set for July 12 and 13, and September 20 and 21, both at the OSMA Headquarters' Office.

Adjourned.

ATTEST: Hart F. Page Executive Director

Annual Meeting Attendance

ATTENDANCE AT THE 1975 OSMA Annual Meeting included member physicians from 84 of Ohio's 88 counties. In all, 1,058 members of the Association were present. In addition, 147 guest physicians and 52 medical students attended, making a total of 1,210 physicians and future physicians. Persons registered as scientific, health education and technical exhibitors numbered 393. Also present were 1,087 persons registered as members of the Woman's Auxiliary, nurses, technicians, other professional personnel and miscellaneous guests. The total attendance was 2,737. Following are tabulated figures on Annual Meeting attendance.

1975 ANNUAL MEETING REGISTRATION BY COUNTIES WITH OSMA MEMBERSHIP DATA

County	MEMBER Dec. 31 1974	SHIP May 11 1975	Annual Mtg. Registration	County	MEMBER Dec. 31 1974	RSHIP May 11 1975	Annual Mtg. Registration		
Adams	12	11	1	Logan	17	21	4		
Allen	138	141	21	Lorain	233	226	18		
Ashland	27	28	4	Lucas	668	611	36		
Ashtabula	61	59	4	Madison	16	15	6		
Athens	40	37	5	Mahoning	3 50	334	14		
Auglaize	16	14	0	Marion	92	89	14		
Belmont	59	60	4	Medina	56	53	2		
Brown	18	16	1	Meigs	5	5	2		
Butler	204	187	18	Mercer	18	18	2		
Carroll	9	9	1	Miami	67	64	9		
Champaign	14	14	3	Monroe	8	2	2		
Clark	143	140	17	Montgomery	694	681	47		
Clermont	20	20	3	Morgan	4	4	1		
Clinton	22	21	2	Morrow	7	7	2		
Columbiana	75	78	8	Muskingum	83	78	12		
Coshocton	20	19	3	Noble	2	2	0		
Crawford	38	34	7	Ottawa	24	26	3		
Cuyahoga	2,306	2,040	124	Paulding	8	7	2		
Darke	26	27	3	Perry	9	6	ō		
Defiance	27	27	4	Pickaway	22	21	5		
Delaware	27	26	9	Pike	13	9	1		
Erie	71	66	4	Portage	66	63	5		
Fairfield	50	50	13	Preble	7	7	1		
Fayette	13	13	2	Putnam	7	6	2		
Franklin	990	891	286	Richland	134	133	27		
Fulton	16	14	1	Ross	46	43	10		
Gallia	36	35	5	Sandusky	49	47	4		
Geauga	30	32	1	Scioto	73	71	3		
Greene	58	56	6	Seneca	40	41	6		
Guernsey	26	23	3	Shelby	20	20	2		
Hamilton	1,361	1,254	80	Stark	379	359	22		
Hancock	45	46	5	Summit	648	606	31		
Hardin	21	23	2	Trumbull	151	152	8		
Harrison	9	9	3	Tuscarawas	52	54	9		
Henry	10	9	4	Union	17	16	3		
Highland	13	13	3	Van Wert	18	15	4		
Hocking	8	7	3	Vinton	1	0	0		
Holmes	9	10	4	Warren	14	14	0		
Huron	31	30	6	Washington	33	36	8		
Jackson	10	8	1	Wayne	62	62	6		
Jefferson	78	78	8	Williams	22	24	2		
Knox	39	38	8	Wood	42	40	2		
Lake	132	134	11	Wyandot	9	8	3		
Lawrence	23	24	4	Honorary	5	5	5		
Licking	77	75	11	TOTAL	10,749	9,978	1,058		
Dicking	• • • • • • • • • • • • • • • • • • • •	, ,	**			-,-,-	-,		

continued on next page

OSMA Annual Meeting Registration — 1919 to 1975

Year	Place	Members	Guest Physicians	Medical Students	Woman's Aux.: Mis. Guests	Sc. and Tech. Exhibitors	Total
1919	Columbus	1173			264	92	1539
1920	Toledo	860			105	80	1062
1921	Columbus	1275			104	96	1503
1922	Cincinnati	1066			184	70	1341
1923	Dayton	1117			202	76	1414
1924	Cleveland	1301			180	109	1603
1925	Columbus	1204			361	107	1689
1926	Toledo	903			120	83	1125
1927	Columbus	1320			286	82	1705
1928	Cincinnati	916			92	80	1115
1929	Cleveland	1231			249	124	1619
1930	Columbus	1241			435	86	1775
1931	Toledo	826			198	50	1087
1932	Dayton	978			201	45	1226
1933	Akron	858			160	25	1049
1934	Columbus	1069			410	51	1539
1935	Cincinnati	973			197	84	1271
1936	Cleveland	1099			563	137	1818
1937	Dayton	1103			366	64	1551
1938	Columbus	1330			619	104	2068
1939	Toledo	1056			271	84	1426
1940	Cincinnati	1126			323	114	1589
1941	Cleveland—Joint Meeting				343	111	1303
1942	Columbus	1221			527	119	1880
1943	Columbus	544			160	113	717
1943		830			411	130	1421
	Columbus	030			711	130	1741
1945	No Meeting	1069	130	65	507	157	0101
1946	Columbus	1262		15	411	157	2121
1947	Cleveland	1502 1362	158 293	27	491	328	2414
1948	Cincinnati			221		214	2387
1949	Columbus	1533	162		462	230	2608
1950	Cleveland	1587	260	102	707	376	3032
1951	Cincinnati	1208	162	185	647	352	2554
1952	Cleveland	1366	204	49	687	395	2701
1953	Cincinnati	1155	180	224	578	298	2435
1954	Columbus	1222	197	173	701	252	2545
1955	Cincinnati	1360	211	185	738	317	2810
1956	Cleveland	1601	338	120	1029	489	3577
1957	Columbus	1164	149	320	689	368	2690
1958	Cincinnati	1327	164	45	674	325	2535
1959	Columbus	1359	293	445	721	364	3182
1960	Cleveland	1642	489	48	1026	447	3652
1961	Cincinnati	1256	231	24	751	301	2563
1962	Columbus	1304	265	343	736	371	3019
1963	Cleveland	1502	336	19	893	441	3191
1964	Columbus	1428	332	297	1002	376	3435
1965	Columbus	1330	275	335	968	394	3302
1966	Cleveland	1484	309	22	865	355	3035
1967	Columbus	1327	286	394	1178	405	3590
1968	Cincinnati	1300	230	35	1287	613	3465
1969	Columbus	1344	219	208	1780	518	4069
1970	Columbus	1160	189	224	1355	477	3405
1971	Columbus	1049	159	182	1116	451	2957
1972	Cincinnati	1118	204	37	1172	498	3029
1973	Columbus	1100	130	93	1260	431	3014
1974	Cleveland	1048	101	26	1010	405	2590
1975	Columbus	1058	147	52	1087	393	



The name's been changed! No longer is it the "Woman's Auxiliary to the OSMA." It is now "The Ohio State Medical Association Auxiliary," Membership qualification has changed too. Husbands of women physicans who are not themselves medical doctors are now eligible for membership. These and other changes in the auxiliary By-Laws were voted upon at the thirty-fifth annual convention held in Columbus at the Christopher Inn May 11-14. The changes in name and membership eligibility were in accordance with similar changes enacted by the national auxiliary which is now officially "The American Medical Association Auxiliary."

The 1975 annual meeting was jam-packed with business activity and social activity, all efficiently and smoothly "administered" by Mrs. S. J. Glueck, 1974-75 president. Her terrific "back-up team" were convention co-chairmen Mrs. Donal O'Leary and Mrs. Patrick Creedon. And there were many, many other "helping hands" from the membership of the Franklin county auxiliary. Ohio was particularly honored this year with the presence of Mrs. Howard Liljestrand of Hawaii, national auxiliary president. And the frosting on the cake was the gracious Dr. Liliestrand himself. Other outof-town guests included the presidents and presidentselect from Indiana, Michigan and Pennsylvania.

Down to Business

Subsequent to the pre-convention Board meeting and luncheon on Monday, the Mini-Workshops for county leaders and district directors took center stage. The "production" featured the specifics of the Project Bank, leadership, legislation, communications, AMA-ERF and parliamentary procedure. Mrs. Robert E. Krone, state president-elect, presided over this "Forecast—1975-76."

The formal opening of the 1975 annual meeting was on Tuesday morning, May 13 with Mrs. Glueck, state president, presiding. Her report on her year of auxiliary stewardship was presented to the House of Delegates (the *Journal* has detailed that report on page 483). Another very important report was that of Mrs. Karl Wieneke, Nominating Committee chairman, following which the nominees as presented by that committee were unanimously elected

The new officers and directors include: Mrs. Robert E. Krone, president; Mrs. William Myers, president-elect; Mrs. S. B. Pfahl, first vice-president; Mrs. Albert May, second vice-president; Mrs. Emil Barrows, third vicepresident: Mrs. W. L. Damschroder, treasurer: directorsat-large to serve two years—Mrs. Armin Melior, Mrs. William Mikita and Mrs. Ernest Fox. District directors this year were elected for the odd-numbered districts: Mrs. Robert Stegemiller, district 1: Mrs. Thomas Allison. 3; Mrs. Kent Brown, 5; Mrs. James Current, 7; Mrs. Ralph Lewis, 9; Mrs. John Emery, 11.

The convention keynote speaker was the national auxiliary president from Honolulu, Mrs. Liliestrand, She detailed a most unusual and eve-opening conversation with a bus driver on a recent trip across Missouri. I don't have the space to write about it now, but I hope to use the incredible experience in a future column. In Mrs. Liliestrand's words, "it made me think about how complex the socio-economic aspects of medicine have become; how the general public misunderstands these problems; and what this bodes for the future of our husbands, their patients and all of us. Also it made me think about Auxiliary, and what we should be doing about this kind of situation that perhaps we aren't . . .

Mrs. Liljestrand discussed at some length the proposed increase in national dues to come before the House of Delegates in Atlantic City in June. "Inflation has cut into the budget severely," she said. "The four P's are what give us trouble: paper, printing, postage and people." She warned that to eliminate any one level of auxiliary will cripple the whole.

The afternoon's business session opened with a moving and tender "In Memoriam" service by Mrs. Carl F. Goll, past state president for the 36 members who had continued on page 520



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PHYSICIAN AND HOSPITAL EQUIPMENT

An Inside Look At The State **Medical Board**



OSMA members often have questions concerning the complex policies and practices of the Ohio State Medical Board. Last month, The Journal carried the first part of an OSMJ interview with William J. Lee, Administrator of the Board (pages 407-411). In this month's conclusion, Mr. Lee discusses several topics affecting Ohio physicians, including Physicians' Assistants, acupuncture, the disabled physician, and the Board's budget.

OSMJ: Physicians' Assistants are becoming a much larger force in the delivery of health care in the state of Ohio. A number of proposals have been made to register or license physicians' assistants under the State Medical Board. In fact, an OSMA proposal is pending in the Ohio House of Representatives. Has the Board taken a position on this issue? If so, what is it?

LEE: They have not voted, as I can recall.

OSMJ: What about Opticians or Physical Therapy Assistants?

LEE: The Board feels that Opticians should not be licensed and I think OSMA has gotten a memorandum on that point. With respect to physical therapy assistants, I don't believe that issue has come before the Board.

OSMJ: I'm sure that the Board is under a great deal of financial stress, as are most licensing authorities within the State. How much money does the Medical Board spend each year? How much more do you think it would take to do a better job?

LEE: I wish I could say we had enough money to do what we'd like to do, but I can't say that. When I first joined the Board, I asked the Legislature for an additional \$100,000 to beef up our enforcement effort. Unfortunately, the legislature refused the request.

In the fiscal period since July 1973, we have spent approximately \$877,000. At a recent hearing before the Senate finance committee, we requested approximately two million one hundred thousand dollars. This would allow the Board to increase its investigative staff, and obtain additional legal assistance.

Our budget is very important to us. OSMA has given us excellent assistance with regard to obtaining money, particularly at the Senate Finance Committee Hearings.

OSMI: What more could OSMA do to help your witnesses before legislative committees, not only in fiscal areas but other areas as well? Where can OSMA be of the greatest help to you?

LEE: Well, I think your presence and statements at the budget hearings are great. Frankly, I'm also finding some excellent support from your academies and medical societies around the state. Just today, we were working hand in glove with an academy concerning a physician who unfortunately has become disabled from a mental problem.

The academies should feel free to criticize us as long as they're sure the criticism is completely justified. It's important to look at the facts and viewpoints and make certain we don't get into situations of unjust criticism. On the other hand, it's imperative to criticize when constructive criticism is warranted. The academies should also work with and assist the local prosecutors in situations where there are violations of the Medical Practice Act.

OSMJ: Does the Medical Board currently participate in any program assisting physicians to rehabilitate themselves from problems like drug dependency, alcoholism, or emotional disturbances?

LEE: We are into this quite extensively although we don't have a formal drug dependency agency program. If we find a physician having drug dependency, alcohol, or any problem of that kind, we immediately conduct an investigation to find out exactly what's going on. Usually the local enforcement officials are involved in the matter.

We've had substantial success in obtaining licensure surrenders or taking formal action to revoke the license. When we get into matters related to surrenders of licensures, we encourage the doctor to have his physician submit medical reports about his progress. The Board usually requires advice and counsel of two physicians indicating that he is qualified to go back into practice.

OSMJ: This sounds very similar to the proposed AMA disabled physician act, currently a part of the medical practice act revisions proposed by OSMA to the state legislature.

LEE: Yes.

OSMJ: I assume you are in favor of the rehabilitation programs being proposed in this legislation.

LEE: I most assuredly am and I have worked to some extent with Mr. Robert Clinger, Dr. Milton Parker, and OSMA's Committee on Mental Health in this regard. I think it's an excellent program and really not that difficult to administer. Of course, OSMA's program is independent of the State Medical Board.

OSMJ: Do you think the Medical Board has sufficient authority today to deal with the incompetent or incapacitated physician? Would the Board like to see any particular changes in the medical practice act to make the language more objective?

LEE: Yes, I do think the powers of the Board can properly be enlarged. We have been working together with regard to language that would give the Board the power to deal with people not practicing according to accepted and reasonable standards. However, I don't want the statute to get us into every case of negligence in the state.

We just don't have the staff to handle every doctor that commits an act of negligence. However, in cases where there is a pattern of incompetency, failure to care, or improper medical practice, then I think the Board should get involved.

OSMJ: It's been our observation that when the Board does get into those cases and suspends or revokes a license, the doctor can appeal this suspension or revocation to the courts. He or she can then re-obtain the license the State Medical Board has declared the individual shouldn't have. Can you explain to us that appeals mechanism and why the State Medical Board is often unable to enforce its findings?

LEE: The statutes of Ohio have a due process procedure. If a person wants to appeal a license suspension or revocation, the Board makes an extensive effort to prepare and certify his or her file for the common pleas court. During the time this preparation takes, the person has the right to go into court and ask for a stay of the Board's order of suspension or revocation.









If the court finds there is undue hardship on the doctor, it will usually grant that person the right to practice during the appeals process.

Under Ohio statutes, the court of common pleas will uphold the Board's order suspending or revoking a license if it finds reliable, substantial, and probative evidence. If such evidence is not found, the court has the right to reverse our suspension or revocation. We may then appeal that reversal but only if there is a question of law involved.

If the licensee loses before the common pleas court, he can go to the court of appeals. In some cases, he can go to the Supreme Court of Ohio and on to the United States Supreme Court.

OSMJ: So, the licensee can continue to practice while his appeal is being processed?

LEE: Yes, if he gets a stay from the court and almost invariably the court will give a stay.

OSMJ: How do we stop that?

LEE: The law should be changed so that judges look not only at the hardship on the doctor but at the hardship on the public if he continues to practice. Now the court grants a stay to give the doctor the right to continue his profession so that if he is ultimately successful in his appeal, he will not have been done out of his professional practice during the interim period. But the public good should be considered.

OSMJ: It's a ticklish situation, I'm sure.

LEE: Yes sir!

OSMJ: What is the Board's position on acupuncture?

LEE: The Board has taken the position that only medical doctors, osteopathic doctors, and podiatrists within a limited scope, can practice acupuncture. It has to be done under the proper protocol and preferably is reviewed by the county medical society or hospital.

We feel acupuncture is an experimental procedure. Written consent has to be obtained from the patient who

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must also understand that it is an experimental procedure. This position agrees with the Food and Drug Administration's Guidelines. However, it is currently being contested by one of the chiropractic associations.

OSMJ: What are the two chiropractic groups and why is only one protesting your position on acupuncture?

LEE: The larger group is the Ohio State Chiropractic Association. Its members are protesting since they believe their scope of practice is broad enough to include acupuncture. The smaller group, the Chiropractic Association of Ohio, feels the practice of chiropractic is limited to the manual adjustment of the subluxations of the spine.

OSMJ: Some Ohio M.D.'s advocate that physical therapists in the future should be performing acupuncture. Our understanding of the current physical therapy law would prohibit any subcutaneous activity. Is that

your interpretation also?

LEE: Yes, that is correct.

OSMJ: Changing the subject again, what specific procedure should an OSMA member follow in order to bring a problem to the attention of the State Medical Board?

LEE: That's an excellent question. I suggest the matter be reduced to writing and presented directly to me or directly to the Board. At that time, we can further investigate the situation. It's imporant for complaints to be in writing so we have an official record. Certain sensitive areas come up where perhaps an oral complaint

would be justified, but we would like to get something down in writing. We have had a number of complaints coming in through OSMA members, and we try to check them out carefully.

OSMJ: Do you then follow up with the member who has filed the complaint so that he or she is kept informed of the Board's activities?

LEE: Yes, we make an effort to do that. However, while the investigation is going on, we sort of lose contact. There's not a blow by blow account of what is going on because we're so interested in pursuing any violation of the law.

OSMJ: We've been asking most of the questions today. Do you have any general comments that you'd like to make to express your thoughts to OSMA's membership?

LEE: It's extremely important for OSMA members to criticize constructively when necessary. But when the heat is on, the academies and the association should make sure they understand the complete factual situation before leveling criticism. I do feel it's very important to use good, sound checking before criticizing.

Secondly, OSMA and the State Medical Board must work closely on matters of common interest and concern, yet keep a sound statutory distinction. The Medical Board should in no way attempt to control OSMA nor OSMA control the Board. This policy has worked in the past and can continue to work in the future.



continued from page 515

died this past auxiliary year. The remainder of the afternoon was devoted to the proposed changes in the By-Laws as given by Mrs. Louis Loria, By-Laws chairman. These changes were voted upon and approved. Elections were also held Tuesday afternoon for the 1975-76 Nominating Committee. At a late afternoon reception, Mrs. Glueck and Mrs. Krone entertained county presidents and presidents-elect as well as Board members.

The President's Breakfast

The fact that the President's Breakfast on May 14 was held at seven-thirty in the morning certainly didn't phase our women! They were there en masse not only to start the day with a good breakfast (isn't that what the doctor orders?) but to participate in what was designated a "Summit Meeting." Twenty-four county leaders detailed their outstanding projects during 1974-75.

At the third business session Wednesday morning, the results of the previous day's election for the 1975-76 Nominating Committee were announced: Mrs. Glueck and Mrs. Armin Melior from the Board; Mrs. Ronald Chapnick, Mrs. Donald Lewis, Mrs. Lee Vesper, Mrs. Daniel Wolff and Mrs. Charles Young from the general membership. AMA-ERF awards were presented to Clark county for the greatest increase and Tuscarawas county for greatest per capita. Also honored for the largest contributions in their respective membership categories were Delaware, Tuscarawas, Muskingum, Allen, Summit, Hamilton and Cuyahoga counties. As of convention, \$72,398.33 had been raised for AMA-ERF. Awards were presented to these counties for outstanding increases in membership: Columbiana, Crawford, Darke, Delaware, Greene, Guernsey, Lucas, Scioto and Washington.

In a particularly beautiful and impressive installation ceremony, the national auxiliary president spoke of the challenges to be met by the new officers and directors. She charged the general membership itself with a renewed sense of its own responsibilities. Lovely Hawaiian leis of orchids, a gift from Mrs. Liljestrand, were presented to each new officer and director by the gallant Dr. Robert E. Krone in an extra-special kind of presentation (believe me, it was *very* special!)

Inaugural Address

"To communicate is the beginning of understanding," said Mrs. Krone, Ohio's new president. "The key words are who, what, why, where and how. Who are we? What are we doing? Why are here? Where are we going? How do we proceed? She urged the counties to continue their efforts in legislation, health education and AMA-ERF.

National's new Project Bank was described as "a means of communication, a way of sharing ideas . . . it means less formal reporting in triplicate, less emphasis from the top on priorities, more responsibility on your part to do the best you can in service to your community . . . the role of the state auxiliary will continue to be that of middleman, we will have fewer chairmen but many more experts . . . "

In her forthright remarks, Mrs. Krone further emphasized that "with a little planning, we can offer a varied menu of activities. It means shopping around to gather together the correct ingredients. Let's provide a balanced diet to utilize the talents of our members, satisfy the desires of our auxiliaries and meet the needs of our communities." (In case you haven't suspected it by now, Fran is a dietitian!)

The Wednesday luncheon was dubbed "Spring Love-In" and honored Mrs. Liljestrand and Ohio's own past presidents (the latter were individually honored with Certificates of Recognition). Guest speaker was John Beljan, M.D., Dean, Wright State University School of Medicine. Prior to the luncheon, the Hamilton county auxiliary (Fran Krone's "home base") was hostess to a reception honoring the new president and her Board. Dr. Maurice Lieber, incoming OSMA president, and Dr. William Porterfield, OMPAC Board chairman, addressed the House of Delegates Wednesday as did Mrs. Mark Brown, outgoinig president of Ohio's WA-SAMA. The traditional past president's pin was given Charlotte Glueck by Mrs. Karl Ulicny, immediate past president, whose words of appreciation about the outgoing president echoed the strong feelings of the membership.

Because of space restrictions, it's impossible to give the whole convention story. But one last mention: the terrific "serenading" of Ohio's new president by her Hamilton county auxilians "This Is The Year for Frances Krone" (to the tune of "This Is The Army, Mr. Jones" and in full chef regalia!)

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obituaries

Herman Samuel Applebaum, M.D., Cleveland; Johns Hopkins University School of Medicine, 1916; age 89: died May 21: member of OSMA and AMA.

Roy Dale Arn, M.D., Dayton: University of Michigan Medical School, 1926; age 75; died May 11; member of OSMA and AMA.

Darrell Dwight Bibler, M.D., Bucyrus; Ohio State University College of Medicine, 1933; age 70; died May 19; member of OSMA and AMA.

John William Camp, M.D., Cambridge: Ohio State University College of Medicine, 1928; age 72; died May 2; member of OSMA and AMA.

John Alexander Davidson, M.D., Springfield; University of Vermont College of Medicine, 1942; age 65; died May 11; former member of OSMA and AMA.

John Frank Docherty, M.D., Conneaut; University of Toronto, 1920; age 81; died May 15; member of OSMA and AMA.

Edward Joseph Fadell, M.D., Louisville, Ky; St. Louis University School of Medicine, 1948; age 52; died May 17.

George Joseph Gabuzda, M.D., Cleveland; Harvard Medical School, 1944; age 55; died May 16.

Samuel L. Greenburg, M.D., Steubenville: Ohio State University College of Medicine, 1930; age 71; died April 26; member of OSMA and AMA.

John F. Lyons, M.D., St. Petersburg, Florida; Indiana University School of Medicine, 1929; age 79; died May 15; member of OSMA and AMA.

Milton Myron Oppenheim, M.D., Cleveland: Wayne State University School of Medicine, 1937; age 65; died May 5; member of OSMA and AMA.

Theodore Iacob Reshetvlo, M.D., Lima: Medical College at Czacow, Poland, 1930; age 72; died May 3; former of OSMA and AMA.

Schuyler C. Rousey, M.D., Cincinnati; University of Cincinnati College of Medicine, 1919; age 86; died May 7; member of OSMA and AMA.

David J. Samon, M.D., Cleveland; Phillips University, Germany, 1953; age 50; died May 30; member of OSMA and AMA.

Samuel Seltz, M.D., Cincinnati; University of Cincinnati College of Medicine, 1923; age 76; died May 16; former member of OSMA and AMA.



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NEW **MEMBERS**

Following are names of new members of the Ohio State Medical Association certified to the headquarters office during May. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

Cuyahoga (Cleveland)

Jeremy E. Alperin Robert G. Corwin James E. Culver Gerson Z. Escondo Victor W. Fazio P. Janardana Kaimal Howard Neiberg Benjamin D. Richman

Franklin (Columbus)

Mohammad A. Chohan Edward F. Jackson, Jr. Louis E. Vassy

Gallia (Gallipolis) Daniel H. Whiteley

Hamilton (Cincinati except where noted)

Anant R. Bhati Cesar F. Cabigon Wade D. Carden Terrace Park Wallace E. Combs Robin T. Cotton Tom Elo Thomas B. Eyl Michael A. Gueasko William M. M. Haskell Robert H. Hermann William S. Lainhart Sara Lewin Thomas K. Lin Milford Kenneth D. Lyon Sylvia A. Manalis Henry W. Neale Kenneth J. Newmark

Robert L. Reed Robert J. Strub Helen J. Tucker

Jefferson (Steubenville) Heung-Joon Yoo

Knox (Mt. Vernon) Daniel E. Michel Roger H. Sherman

Lucas

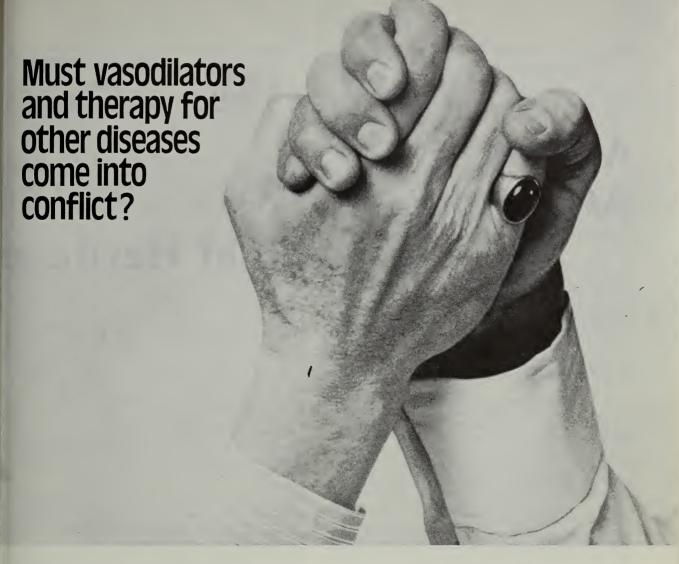
Sharon L. Erel Toledo David B. McConnell Sylvania George G. Rakolta Toledo Sheldon Singal Toledo

Montgomery

Fernando N. Perez Centerville Joseph Premanandan Dayton Harvey T. Staton Dayton

Stark (Louisville) Timothy L. Hirst

Summit (Akron) Manuel C. Abellera John M. Croci Jan H. Cunningham Gary B. Williams



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Possibly Effective:

- 1. For the relief of symptoms associated with cerebral vascular insufficiency.
- 2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
- 3 Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

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THE OHIO STATE MEDICAL JOURNAL IS A BICENTENNIAL PARTICIPANT.

A Look At History— Our Medical Heritage

RICHARD L. MEILING, M.D.

"If men could learn from history, what lessons it might teach us! But passion and party blind our eyes, and the light which experience gives us is as a lantern on the stern, which shines only on the waves behind us."

Samuel Taylor Coleridge (1782-1834)

We the people of the United States of America are celebrating the American Revolution Bicentennial. Our birthday celebration is a proper occasion to review the parentage, lineage, and early history of our nation. As physicians, we should be aware of the heritage left behind by early practitioners of medicine who also were explorers, settlers, frontiersmen, legislators, judges, governors, statesmen, and soldiers.

Even as late as 1776, physicians lived and practiced under complex conditions. Plagues, smallpox, yellow fever, cholera, typhoid, and typhus were of epidemic character.

Sanitation was non-existent.

In making a house-call, the physician not only faced the threat of the patient's disease but also the vermin of his bedclothing and furniture. Housing, when available, was most rudimentary. Pollution and contamination of food and water were commonplace. Therapeutic armamentarium was extremely limited. Communication and transportation were confined to movement by foot and horseback with only occasional roads open for "postcoaches."

The Middle Ages

A review of our medical heritage should begin in the 1500's when the renaissance had not yet awakened science, religion, art, medicine, or politics. In 1453, the city of Constantinople fell to the Moslem Turks, closing the land route between Europe and India. Christian merchant caravans could reach India only by sea and the route along the African coast was long and hazardous.

For ten years, Christopher Columbus pleaded unsuccessfully in the royal courts of Europe for financial

backing to discover a shorter route to India by sailing west. Finally, Queen Isabella of Spain, influenced by the need for expansion of the Catholic faith as well as for a new trade route, succeeded in obtaining financial support for his voyage from the Spanish Court and on August 3, 1492, Columbus sailed from Palos, expecting to reach India.

Three physicians sailed with Columbus. Maestro Juan Sanchez sailed on the Santa Maria, Maestro Alonzo on the Nina, and Maestro Diego on the Pinta. Maestro Juan Sanchez stayed with the settlement that Columbus established upon landing on what we now call San Domingo. The settlement was devastated by natives after Columbus' ships returned to Spain and all were killed.

One of medicine's unsettled controversies is whether Columbus and his crews brought syphilis from the American Indians to Europe. The disease appeared in a virulent epidemic form in 1494 in Europe. However, the diaries of the Nina and Pinta do not indicate illness among the crews during the return voyage.

On Columbus' second voyage in 1493, Diego-Alvarez Chanac of Seville, a "physician-in-ordinary" to the Spanish Court, sailed along. Chanac prepared the first written report (to the Council of Seville) on the natural history, ethnology and ethnography of "The Indies" (Central America.)

Amerigo Vespuccius (1451-1512), a merchant, adventurer, geographer and astronomer from Florence, Italy, first used the words "Mundus Novus," that is, the "New World," to describe South America. Sixteenth Century historians repeatedly used "Amerigo," thus giving the name "America" to both South and North Continents of the Western Hemisphere.

In 1565, Spanish settlers established St. Augustine, Florida. The Spanish also pushed northward from Mexico and the Gulf into the Mississippi River, the Rio Grande River and the Pacific Coast. The English (Cabot, Drake, and Raleigh) were exploring the Atlantic seaboard. No records of medical men accompanying these explorers have been found.

The Renaissance

The renaissance affected medicine in the Sixteenth Century most profoundly. For thirteen centuries the concepts of Galen and Aristotle had shackled medicine in mysticism or the proper mixture of the four humors: phlegm, blood, bile and black bile. The Swiss chemist Paracelsius (1493-1541) introduced the scientific basis upon which medicine could grow. He burned the writings of Galen. Veselius (1514-1564) of Brussels introduced modern anatomy, and Ambroise Paré (1510-1590), a French military Chirurgeon, received respect and acclaim for his surgical technical procedures, surgical and dental protheses, and the treatment of gunshot wounds. These men wrote in the language of the common man (the academicians used Latin) enabling new knowledge to be disseminated rapidly.

Physicians (today we would call them internists) of this century preferred study, discussion and teaching to patient care. The need "to regulate the medical practice of physicians" was recognized in England by Thomas Linacre (1460-1524). Henry VIII granted him the "letters patent for a body of regular physicians" in 1518. The concept of self-regulation of the profession was carried further when the Royal College of Physicians of London was established in 1551. This concept of self-regulation still plagues and puzzles the medical profession more than 450 years later.

The Guild of Surgeons (not incorporated) and the Company of Barbers (incorporated in 1462) became the Company of Barber-Surgeons in 1540. The surgeons (long coats-chirurgeons) treated the injured and sick while the barbers trimmed beards, lanced boils and "did bleeding" (vena-puncture). The apothecaries were tradesmen (apothecary guild incorporated in 1543) and hence were permitted to sell merchandise (drugs). The separation of these two guilds was accomplished by Par-

liament in 1754 when the Company of Surgeons was formed. The Royal College of Surgeons was born of Royal decree in 1800.

These several categories of medical practitioners are to be found on the ships rosters and in the archives of settlements in the Seventeenth Century development of North America.

The Seventeenth Century

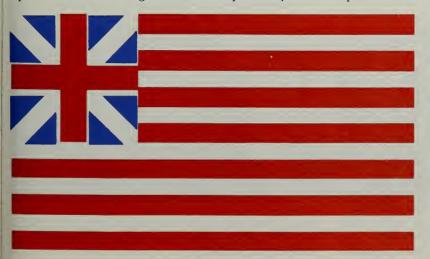
In 1604, a joint venture stock company in which small investors could participate (stock sold at less than \$100 per share, 1975 value) was formed to develop the "Virginia Country." It was christened the London Company.

Captain Bartholomew Gilbert representing the London Company arrived in the "Chespian Bay in the Country of Virginia" in 1603. He spent a landing party ashore including a fleet surgeon, *Henry Kenton*. The party was ambushed and all were killed. Thus the first English Surgeon to land on the Atlantic Seaboard died in duty to Crown, Company and Colonization. On May 14, 1607, the London Company successfully established a settlement on what is now Jamestown Island in the James River of Virginia.

Among the members of this settlement is listed Thomas Watton, a gentleman and Chirurgeon, and William Wilkinson, an indentured servant and Chirurgeon. In 1609, Dr. Walter Russel, listed as a "physician," and Thomas Field and John Hartford listed as "apothecaries," settled in Jamestown. All three categories of practitioners were present in this early Virginia settlement.

Again it was the London Company that arranged the trip for the Pilgrims in the "Mayflower" to join the Jamestown settlement. Faulty navigation resulted in the Mayflower landing on December 21, 1620 at Plymouth, Massachusetts. Samuel Feller, an English physician and clergyman, was a member of the Mayflower settlement.

By 1619, the Virginia House of Burgesses, the first representative assembly in North America, was estab-



The first official flag of the United Colonies retained the Union emblem as decreed by Queen Anne in 1707 for all British flags. The emblem consists of the combined crosses of St. George and St. Andrew and thirteen alternate red and white stripes. When this flag was adopted, the colonists desired conciliation with Britain, not independence.

lished. This legislative body attempted by law in 1639 "to control the practice and fee structure" of medicine. By 1662, this same colonial legislative body was enacting laws "to protect the physician and surgeon when despite his best efforts the patient died." How delightfully similar to social and economic concepts in the practice of medicine in the Twentieth Century, and legislative attempts to control "professional medical liability insurance."

The Eighteenth Century

George III assumed the throne in 1761. With his personally selected Prime Minister, Lord North, he attempted to reestablish royal colonies directly administered by the Crown as differentiated from English colonies in which the colonists enjoyed the "rights and privileges" of an Englishman.

George III requested passage of several notorious acts involving trade, customs, and taxation, and denied the colonists the right to taxation only by representation and the right to trial by jury. The Tea Act (1770) resulted in the now famous "Boston Tea Party" (1773). The English responded by closing the Boston Port and passing the "Coercive or Intolerable Acts." Faced with a multiplicity of colonial problems and goaded into a showdown by the colonists, George III and Lord North attempted a grand strategy.

This strategy was called the Quebec Act of 1774 and placed development of territory west of the mountains and south to the Ohio River under the responsibility of the Province of Quebec. The colonies were bitterly opposed because Quebec supported the propagation of the Roman Catholic Church and because no provision was made for "the right of an elected assembly." Thus, the power struggle began between "John Bull" and his American Colonies, the latter believing their "rights" as Englishmen had been breached.

1774-76

Although approximately 3,500 medical men were recognized in the thirteen colonies at this time, fewer than 50 medical degrees had been granted by America's two medical schools, Pennsylvania and Columbia. (Dartmouth and Harvard medical schools were to be established during the revolutionary period.) Perhaps 50 additional men held medical degrees from oversees schools.

On September 5th, 1774, the delegates of twelve of the colonies (Georgia was not represented) met in Philadelphia in response to the "repressive" acts of the Crown and Parliament. An association (confederation) was formed known to us as the First Continental Congress.

At this time, the Colonists did not desire independence but did demand repeal of the Coercive Acts. Unfortunately, Parliament passed still more repressive legislation, such as the, "The New England Restraining Act." The Military Governor of the Massachusetts Colony, General Gage, dissolved the colony's elected assembly in October, 1774. In defiance, the Province of Massachusetts established a "provisional" congress which met regularly in Concord. Twenty-two physicians were members. The Provisional Congress appointed a "Committee of Public Safety" to gather and recruit minutemen.

Drs. Joseph Warren and Benjamin Church were leaders of this committee. Dr. Warren headed the intelligence service responsible for alerting minutemen if and when the British moved from Boston toward Concord. When Governor Gage did send a "force of redcoats" to seize the stored arms and disperse the Provincial Congress, his troops were resisted at Lexington and Concord.

On the night of April 18, 1775, Paul Revere, Dr. Samuel Prescott (a Boston physician), Mr. Dawes and others made the night ride to alert the minutemen. Revere was captured at Lexington but Dr. Prescott escaped and reached Concord. So successful was Dr. Prescott that the British were stopped at Concord and forced to withdraw with severe losses to Boston under protection of a relief column sent to their rescue.

Armed conflict was now inevitable. The Battle of Bunker Hill (Breeds Hill) on June 17, 1776 was the first stand-up fighting between British regulars and colonial militiamen. Thirty-one physicians and surgeons were in the American fighting ranks. Dr. Joseph Warren and ten other physicians died on this June day in what they believed a just cause, that is the preservation of their rights as Englishmen.

On May 10, 1775, the "Association" (The Second Continental Congress) was called into session again in Philadelphia. Thanks to the efforts of Dr. Lyman Hall, Georgia was now represented so that the thirteen colonies were all present. This "Association" proceeded to create a "provincial army and navy" and to send "diplomatic agents" to Europe. It appointed Colonel George Washington as Commander-in-Chief of the Army of the United Colonies.

The spirit of this Congress was overwhelmingly for concilation rather than separation. Loyalty to the Crown was supreme. Washington opened his officer's mess each evening with a toast to "King George III, Our Sovereign," as was customary in the British army in which he

had served many years previously.

The first official flag of the United Colonies retained the Union emblem as decreed by Queen Anne in 1707 for all British flags. The emblem consisted of the combined crosses of St. George and St. Andrew and the thirteen alternate red and white stripes. Senior Lieutenant John Paul Jones raised this flag on December 3, 1775 over his ship "Alfred." General Washington used it at a barracks parade on January 1, 1776 near Boston.

King George III and Lord North responded to

petitions requesting conciliation by proclaiming that a general rebellion existed. On December 22, 1775, Parliament prohibited all trade with the colonies. In effect, a state of war existed.

Declaration of Independence

By May 1776, the Virginia Convention had instructed its delegates to the Philadelphia Convention (Second Continental Congress) to "declare the United Colonies free and independent." Accordingly, Richard Henry Lee presented an Independence resolution to the Philadelphia Congress:

"That these United Colonies are, and of right ought to be, Independent States, that they are absolved from all allegiance to the British Crown, and that all political connections between them and the State of Great Britain is, and ought to be, totally dissolved.

That it is expedient forthwith to take the most ef-

fectual means for forming foreign alliances.

That a plan of confederation be prepared and transmitted to the respective Colonies for consideration

and approbation."

The Philadelphia Congress voted to postpone consideration of Lee's resolution. The delegates from New York, Pennsylvania, Delaware, and South Carolina had not received instructions on how to vote. Several days later, a committee of five delegates was appointed to prepare a Declaration of Independence. Appointed to the committee were:

John Adams Benjamin Franklin Thomas Jefferson Robert R. Livingston Roger Sherman Massachusetts Pennsylvania Virginia New York Connecticut

Thomas Jefferson wrote the major portion of the Declaration. Before Congress cast its final vote on the evening of July 4, it voted on 86 changes or amendments to the document.

Philadelphia was humid and stifling hot when Congress voted to endorse the Declaration. If the delegates opened windows or doors to relieve the heat, they faced the unrelenting attack of horse flies and mosquitoes. The woolen clothing, wigs, and long stockings worn by delegates were poorly adapted to Philadelphia in July. No fireworks, patriotic speeches, or parades embellished this July 4 action.

New York's delegates abstained from the vote taken on July 4 since they had not received instructions on how to vote. On July 19, New York was finally able to vote "aye" with the other twelve colonies. Congress then officially voted to have the Declaration of Independence signed.

It took six months to acquire the signatures of all 56 Philadelphia Congress delegates. The authenticated copy of the beautifully designed parchment is dated Ianuary 17, 1777.

Little did England in 1776 forsee the entry of France, Holland and Spain into the war on the side of the Colonies. German staff officers such as Von Steuben and deKalb provided the training and logistic organization for General Washington's troops. The French General Lafayette commanded colonial troops while German mercenary soldiers from the Prince of Hesse's forces served with the British troops. This international involvement was to establish a pattern for all future American military activities.

Today, we tend to forget that the American Revolution War was actually also a "Civil War". The Loyalists or Tories of the colonies supported the Mother Country. The fighting between Loyalist and Patriot partisan (guerrilla) bands was most vicious with neither side giving any quarter. The massacre of the garrison at New London and the farmers of Wyoming Valley are prime examples of the acts of violence committed in the name of the American cause. (The alleged acts of violence in South Viet Nam have historical reference if one follows the paths of warfare beginning with American forces of 1776-1781.)

Most Anglican ministers (Episcopalians) in the middle and northern colonies remained loyal to their oath to the King as Head of the Anglican Church. When the British evacuated New York City, the rector of Trinity Church and his entire congregation (parish) went with the British under General Howe. Does this

Of the 56 men who signed the Declaration of Independence, six worked in the field of medicine.



Get Taylors Benjamin rush Oliv. Notes 4. Mollow Trombon God. Lyman Holl, Josiah Bartleto

seem so strange when compared with the recent evacuation of Saigon, South Viet Nam in 1975? It is said New York State furnished more troops to the King's service than she did to Congress of the United Colonies.

The colonies' cause evoked great sympathy in England. The Earl of Effingham, the colonel of a British regiment ordered to America, turned in his commission because "duties of a soldier and a citizen had become inconsistent." He was publicly congratulated on his stand by the City corporations of Dublin and London. Vice-Admiral Keppel of the Royal Navy and General Sir Jeffrey Amherst refused to serve against their brother Englishmen in the American Colonies. (This too carries overtones for the individuals who disagreed with the American Policy in Southeast Asia in 1960-1975.)

Signers of the Declaration of Independence

Among the fifty-six who signed were six citizens who either practiced or had prepared to practice medicine. (Author's Note: Some authorities name only five, but following the lead of the American Medical Association's publication *Today's Health*, July, 1961, I also include the name of George Taylor.) The six medical men were:

Josiah Bartlett (Delegate from New Hampshire) He was a respected country physician who served as a colonel in the militia. He also served as a justice of peace and was elected the first Governor of the state of New Hampshire.

Lyman Hall (Delegate frrom Georgia) He was a native of Connecticut. He and Dr. Wolcott were members of the class of 1747 of Yale College. After



OHIO IN THE REVOLUTIONARY PERIOD

practicing medicine in Wallingford, Connecticut, he migrated to Georgia by way of South Carolina. Dr. Hall combined operation of a plantation with practice of medicine. In 1783, he was elected Governor of Georgia and was instrumental in establishing the University of Georgia, the first state owned University in the United States (preceding the Land-Grant Colleges by almost 100 years).

Benjamin Rush (Delegate from Pennsylvania) He studied medicine in Philadelphia, London and Edinburgh. General Washington removed him as "Surgeon General" of the Army because he allegedly was conspiring to have Washington removed as Commander-in-Chief. President John Adams appointed Dr. Rush as Treasurer of the Philadelphia Mint. Richard Stockton, also a signer of the Declaration of Independence, was Dr. Rush's father-in-law. Rush is considered the outstanding American scientist and medical man of his time.

George Taylor (Delegate from Pennsylvania) An emigrant from Ireland, he served as a colonel in the militia. He had studied and was apprenticed in medicine although he operated an iron furnace to earn his living. Dr. Taylor was named a delegate on July 20 in place of another Pennsylvania delegate who opposed separation from England. This was a true example of early "political convention democracy." Although he did not vote on July 4, Dr. Taylor did sign The Declaration in August.

Matthew Thornton (Delegate from New Hampshire) He was an emigrant from Ireland of Scottish parentage. He served in 1740 as "Under-Surgeon" with the New Hampshire troops, participating in the Louisburg expedition to Cape Breton in 1745.

Oliver Wolcott (Delegate from Connecticut) He was absent on July 4 when the vote was taken, but in October, 1776 he signed the Declaration of Independence. He practiced medicine in Goshen, Connecticut. As mentioned above, he and Hall were in the class of 1747 at Yale. He served as sheriff of Litchfield, a judge, and a Major General of the militia. He was elected Governor of Connecticut in 1796. His father had served as Governor of the Connecticut Colony and his son later became Governor of Connecticut.

Medicine in the Continental Army

Unfortunately, the medico-military affairs of the Army between 1776 and 1781 were steeped in politics, personal aggrandizement, alleged treason, and graft. Care of the soldiers was poor or non-existent.

Dr. Benjamin Church of Massachusetts, the Continental Army's first medical director, was convicted of holding criminal correspondence with the enemy and dishonorably discharged. His successor was Dr. John Morgan who had founded the colonies' first medical school in Pennsylvania ten years earlier.

Dr. Morgan became involved in a personal vendetta with Dr. Samuel Stringer, head of military medicine in

Northern New York, and Dr. William Shippen, head of the Hudson's western side. Congress subsequently dismissed Morgan and Stringer. Shippen, who had two brothers-in-law serving in Congress, was appointed as the new Army Medical director.

In the meantime, Congress exonerated Morgan. With the help of Dr. Benjamin Rush, Morgan had Shippen court-martialed in 1780. Shippen resigned a year later. (Shippen was later acquitted of charges of improperly handling funds and supplies, although not all evidence was in his favor).

Dr. Benjamin Rush, a member of Congress and signer of the Declaration of Independence, also became involved in the Army's internal squabbles. When he lost reelection to Congress in 1777, Rush was commissioned "Physician General of the Middle Department." Rush wrote a letter criticizing General Washington and sent it unsigned to Patrick Henry, Governor of Virginia. Henry forwarded the letter to Washington. It arrived at a time when Washington feared there was a conspiracy to replace himself with General Gates as Commander-in-Chief of the Army. The letter made Rush guilty by association and he resigned his commission in 1778, returning to his practice at Princeton, New Jersey.

These are only a few of the internal squabbles of the Army Medical Department during a time when epidemics of smallpox, yellow fever, dysentery, typhoid, and typhus decimated the ranks of Washington's troops. Dr. Rush stated "Fatal experience has taught the people of America . . . that a greater proportion of men have perished with sickness in our armies than have fallen by the

sword." (The Military Surgeon, 1908).

Britain's General Cornwallis surrendered to Washington at Yorktown on October 19, 1781. Sixteen months later the Treaty of Paris officially ended the American Revolution, and in 1789 General Washington was inaugurated as the First President.

Ohio Country

The French explorer, La Salle, is said to have been the first European to pass down the Ohio River, in 1669. The English in 1685 licensed Johannes Rooseboom, a Dutchman, to trade along Lake Erie. The Treaty of Utrecht (1713) gave France vague claims to the Great Lakes Region. From 1700 to the 1750's, New York, Virginia, and Pennsylvania helped shape the destiny of the Ohio Country.

In 1748, the first "Ohio Land Company" was organized and King George II granted it a Charter. Composed of London and Virginia merchants, the Company's mission was to colonize the West. Later, the Quebec Act, passed under George III in 1774, placed all Ohio Country under the Province of Canada.

Following the Revolutionary War, England wanted to win the United States away from France. At the Treaty of Paris (1784), England gave the new nation the Mississippi River as its Western border and the Great Lakes as its Northern border. Thus, the Ohio Country

became a part of the United States.

Maryland refused to sign the Articles of Confederation (our first Constitution) until Congress promised all the Northwest Territory would be disposed for the common benefit of the United States, disregarding the claims of New York, Virginia, Massachusetts and Connecticut. Land speculators were displeased with this solution. Congress then enacted the Ordinance of 1784 providing a territorial government for all the region West of the mountains.

The second Ohio Land Company was organized in Boston in 1786. It was composed chiefly of Revolutionary War Veterans from New England. Its objective was to found a new "state" between Lake Erie and the Ohio River. The Company lobbied for the Northwest Ordinance of 1787, enacted by Congress in 1787, providing step-by-step development of the Northwest as a state or states co-equal in the United States.

The Ohio Company founded Adelphia at the confluence of the Ohio and Muskingum Rivers in 1788. Now known as Marietta, it is regarded as the oldest settlement in Ohio. John C. Symmes settled land along the Ohio River at Columbia (1788) and Cincinnati (1789) with people from New Jersey. Virginia veterans settled at Manchester (1790) and Chillicothe (1796). Connecticut people, led by Moses Cleveland, founded Cleveland (1796) and later Youngstown.

Ohio's territorial period was between 1787 and 1803 with General Arthur St. Clair as the first territorial Governor. Congress passed the Enabling Act on April 30,

1802, establishing Ohio as a state.

Several physicians were active in Ohio's early years. Dr. Edward Tiffin (1766-1829) lived and practiced medicine in Chillicothe. He was elected Speaker of the Territorial Legislature in 1799; President of the Ohio Constitutional Convention in 1802; and first Governor of Ohio in 1803. Two years later he was elected to the United States Senate, later resigning to become member and speaker of the eighth and ninth Ohio General Assembly.

Dr. Alexander Campbell (1779-1857) practiced medicine in Ripley, Ohio. He served as member and Speaker of the Ohio House in 1807-08 and United States Senator in 1809.

The first practicing physician in Ohio is said to have been Dr. Jabez True (1760-1823). He came to Marietta from New Hampshire in the early summer of 1788. Another New Hampshire physician, Dr. Samuel Prescott Hildreth migrated to Marietta in 1806. In 1811, Dr. Hildreth was elected to the Ninth Ohio General Assembly which met in Zanesville. He authored the first law regulating the practice of medicine in Ohio.

As the media overwhelms us with facts about the Revolution during the coming year, perhaps this high-lighted sketch of our medical heritage will be a helpful reference. Even such a brief sketch shows that our medical ancestors proved themselves by citizenship and leadership as well as by scientific and humanistic care of their patients. As physicians we dare not neglect our role as citizens in an ever-changing society.

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In This Issue:

Air Force Opportunities522
Boehringer-Ingelheim Ltd445-450
The Brown Pharmaceutical Co., Inc454-455
Burroughs Wellcome Co
Capital Financial Services518
Dorsey Laboratories, Div. of Sandoz-Wander, Inc
Lilly, Eli and Company458
Mead Johnson Laboratories523
The Medical Protective Company519
Menendian, K.A. Carpets455
Ohio Medical Indemnity478
Palms of Pasadena Hospital470
The Park Plaza Hotel442

Pharmaceutical Manufacturers Association444-445
Roche Laboratories, Div. of Hoffman- LaRoche, Inc Inside Front Cover, 441, 486, 487, Inside Back Cover, and Back Cover
Roerig & Co., Div. of Pfizer488
Searle Laboratories, Div. of G.D. Searle & Co
SK&F Co., Subsidiary of Smith, Kline
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Turner & Shepard, Inc530
University Center520
The Upjohn Company476-477
Wendt-Bristol Co515
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Original and Scientific Articles

DISSEMINATED INTRAVASCULAR COAGULATION ASSOCIATED WITH INFLUENZA Harold Settle, M.D., and Helen I. Glueck, M.D., Cincinnati	541
PRESSURE PULSE VELOCITY MEASUREMENT: AN INDEX OF THYROID FUNCTION Jack Marks, M.D., Columbus	544
AVASCULAR NECROSIS OF THE FEMORAL HEAD IN THE ADULT Thomas H. Mallory, M.D., Columbus	548
Special Articles	
OHIO PRISON INMATES RECEIVE ONLY "CRISIS" MEDICAL CARE	565
S/UR SYSTEM MONITORS MEDICAID EXPENDITURES Marjorie G. Kelley, Ph.D.	573
A COMMUNITY HOSPITAL REVAMPS ITS CONTINUING EDUCATION Ralph E. Pickett, M.D.	576
KING GEORGE III'S INSANITY PORPHYRIA: A ROYAL MALADY Frank Batley, Esquire, M.B., Ch.B.	578
ROSTERS State Association Officers, Executive Staff, and Committeemen County Society Officers and Meeting Dates	589
Features	

News	555,	New Members	582
	556,	Woman's Auxiliary	596
	563,	Continuing Education	587
	564	Obituaries	581
Ohio Health News	574	Journal Advertisers	598
The Federal Scene	572	Classified Ads	599

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Disseminated Intravascular Coagulation Associated with Influenza

Harold Settle, M.D. Helen I. Glueck, M.D.

A case report is presented of a 75-year-old man with influenza pneumonia A-England/42172 infection, proven by nasopharyngeal culture and antibody determinations, who developed disseminated intravascular coagulation (DIC). The DIC syndrome diagnosis was supported by a prolonged partial thromboplastin time and prothrombin time, a low fibrinogen level, depression of platelets, and an abnormal staphylococcal clumping test. The patient was treated with heparin and made an uneventful recovery. He also was documented to have metastatic carcinoma of the prostate gland.

Although DIC can be associated with carcinoma, once the patient had recovered from the acute DIC infection, no further evidence of DIC was noted even though the presence of carcinoma was confirmed. Since influenza is a common occurrence, DIC should be more diligently sought for in such patients.

DISSEMINATED INTRAVASCULAR coagulation (DIC) is seen with a variety of bacterial infections, particularly gram negative organisms. It has also been reported in association with viremia, particularly rubella and rubeola. However, there are few reports in the English literature of DIC associated with a documented influenzal infection. This report describes such a patient.

Case Report

A 75-year-old white man was admitted to the Cincinnati Veterans Administration Hospital on February 15, 1973, when an epidemic of the influenza was occurring locally. He had been ill for two or three days prior to admission, with symptoms consisting of fever, malaise, anorexia, dyspnea, and orthopnea. In addition, on the day of admission, he had lost consciousness, had fallen, and was nonresponsive when admitted. Physical examination revealed a temperature of 38.5 C (101.3 F), pulse rate 108

beats per minute, respirations 40 per minute, shallow and labored, and blood pressure 130/80 mm Hg. He was somnolent and in moderate respiratory distress. The neck veins were not distended. The chest was of normal anteroposterior diameter. Diffuse rales were heard throughout both lung fields. The cardiovascular examination revealed irregular rhythm with numerous extra systoles. The nail beds were cyanotic without clubbing. Peripheral edema was absent. The prostate was somewhat firm and nodular and at a later date, a needle biopsy revealed prostatic carcinoma. After recovery from the acute illness, x-ray survey revealed osteoblastic metastases in the wrist. Although DIC can be associated with carcinoma, once the patient had recovered from this acute infection, no further evidence of DIC was noted.

On admission, several large ecchymotic, purpuric lesions were noted on the thigh and the chest wall; and there was some purpura below his knees. The largest ecchymotic lesion had apparently resulted from the fall preceding admission. The patient's voided urine contained bright red blood. However, his stools were consistently guaiac negative. His admission hematocrit reading was 41 percent and the hemoglobin value was 13.8 gm/100 ml

but within six hours, his hematocrit level had fallen to 29 percent and the hemoglobin value to 10.2 gm/100 ml. The initial white blood count (WBC) was 9,400 per cu mm and remained in the range of 9,400 to 12,600 per cu mm during his entire illness. Arterial blood gasses with the patient breathing room air revealed serum pH of 7.35, arterial carbon dioxide pressure (pCO₂) of 59 percent, and arterial oxygen pressure (pO2) of 34. The electrocardiogram revealed atrial fibrillation. The chest x-ray film did not demonstrate any specific infiltrates, even though many rales were heard and the patient was markedly dyspneic. No pathogenic bacteria were cultured from the blood or sputum. However, influenza pneumonia A-England/42172 was cultured from his nasopharynx on a sample obtained on the day of admission.3 Herpes virus was likewise cultured from the same sample. Influenza antibody determinations were determined by complement fixation (CF) and hemagglutination inhibition (HAI)4 The initial amount by titer (CF) was greater than 256; the convalescent value was 64. With HAI antibody, the acute and convalescent titers were both 160. These findings confirmed the diagnosis of influenza.

A prolonged partial thromboplastin time (PTT), prothrombin time, and a low fibrinogen level, as well as a depression in the number of platelets, suggested the diagnosis of disseminated intravascular coagulation (DIC). The table summarizes the coagulation profile. The prolonged prothrombin time and PTT reflected an associated depression of factors V, VIII (AHG), and fibrinogen. The platelets, although not enumerated were markedly decreased, no more than two per oil emersion field being observed. Fibrin degradation products (FDP) measured in the serum were grossly increased. The staphylococcal clumping test was likewise markedly abnormal.⁵ The latter assay measures early FDP products complexed with soluble fibrin monomer complexes. The serial dilution protamine test for fibrin monomer was positive in both the early and 24-hour samples, suggesting circulation of fibrin monomer (early sample) and fibrin degradation products (late sample).6 Soluble fibrin (fibrin monomer) was measured.7 This assay of soluble fibrin, which is independent of fibrin split products, was at the upper limits of normal. However, the half-life of this product in contrast to FDP is brief;8 and the optimum period might have been overlooked. Therapy was commenced with 5000 units of heparin intravenously every four hours for a 48-hour period. At the same time, he was given ten units of cryoprecipitate containing approximately 3 grams of fibrinogen and 1500 units of AHG. Because of the anemia, he received two units of packed red cells. Within 24 hours of institution of heparin therapy, his prothrombin time, which had been strikingly abnormal, fell to 12 seconds; and the PTT, which was grossly abnormal, showed striking improvement. The staphylococcal clumping test, however, remained persistently abnormal for five days. The hematoma showed marked enlargement and a new ecchymotic lesion appeared on his chest, so that it was decided to discontinue heparin therapy.

Sodium cephalothin therapy (1 gram intravenously every six hours) was begun on admission. He was maintained on oxygen therapy until the fifth hospital day. Sodium cephalothin was continued until the sixth hospital day, then changed to cephalexin

From the Veterans Administration Hospital, Cincinnati; the Department of Medicine, University of Cincinnati College of Medicine; and the Cincinnati General Hospital.

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Dr. Glueck, Cincinnati, Director, Coagulation Laboratories, University of Cincinnati Medical Center; and Professor of Medicine, University of Cincinnati College of Medicine. Submitted July 31, 1974.

monohydrate (500 mg orally every six hours) until the 15th hospital day. He became afebrile on the seventh hospital day. When restudied some months later, his coagulation profile was completely normal. (See table.)

Methods

Coagulation. Fibrinogen was measured by the method of Ratnoff and Menzie.9 Prothrombin time was the onestage assay of Quick.10 Factor V was measured by the method of Stefanini and Dameshek.¹¹ The partial thromboplastin time (PTT) was that of Sirridge in a completely surface-activated system.12 Factor VIII was quantitated using the activated PTT as previously described. 13 Detection of FDP and fibrin monomer with the serial dilution protamine sulfate test was determined by the method of Gurewich and Hutchinson.⁶ The staphylococcal clumping assay for early fibrin split products plus fibrin monomer complexes was that of Hawiger and co-authors.⁵ Fibrin/ fibrinogen degradation products in the serum were likewise measured using a commercial reagent of latex particles* coated with antifibringen antibodies.14 In normal sera, the titer is 1:5 or less. (1:5 titer=10 μ g/ml FDP). Fibrin monomer distinct from fibrin split products was measured by the method of Kisker and Rush.⁷

Virologic Techniques. Influenza virus was cultured and identified by the method of Robinson and Dowdle.³ Influenza antibodies were determined by complement fixation and the hemagglutination inhibition methods of Sever.4

Discussion

An excellent review of infection and DIC by Yoshikawa, et al¹ indicates that a wide variety of both gram negative and gram positive organisms can be implicated. In their discussion of viruses associated with this syndrome, no mention is made of influenza.

Corrigan, et al¹⁵ studied 36 pediatric patients with septicemia and DIC. Twenty-two presented with gram negative and eight with gram positive infections, two with Rocky Mountain fever, and in four no identifiable organism were isolated. Of 36 patients, none was reported with influenza.

The association of fulminant meningococcemia and DIC is well recognized.¹⁵ Varicella as well as streptococcal infections have been implicated.¹

In contrast to bacterial infection, DIC in association with viremia was infrequently recognized until 1967 when McKay and Margaretten reviewed this subject.¹⁷ The diseases involved included varicella, variola, rubella and rubeola. Less common disorders, such as the hemorrhagic fevers reported from the Far East, were also included. Again, no mention of influenza was made. In a more recent review of viruses and DIC by Merskey,2 no note is made of influenza as a causative agent.

The rarity of this association is unusual when it is realized that influenza, particularly in the elderly patient,

^{*}Thrombo-Wellcotest® (Burroughs Wellcome Co.)

Coagulation Profile and Therapy, Influenza With Disseminated Intravascular Coagulation

Assay	Normal Values	2/15	3 AM	2/16 9 AM	3 PM	8 AM	2/17 3 PM	9 PM	2/18	2/20	2/21	9/12
P) time (sec)	(12.1 ± 1.2)	18	18	29	16	15	12	12	14	12	12	11
PT (sec)	(33 ± 3)	40	68	150	100	120	38	35	33		33	29
Frinogen mg/100 ml)	(>200 mg)	53	54	130		205		310	320	450	550	230
etelets		diminished					adequate		adequate		adequate	adequate
Etor V %	(50 - 150%)			53							100	
Etor VIII %	(50 - 150%)			27							100	
P titer	(1:2 or absent)			>1/200							1/5	negative
Sial prota- nine test	(neg. ½ hr. neg. 24 hr.)			1/10 1/40							negative negative	negative negative
Sphylococcal lumping	(negative)			1/16,384							1/512	negative
Suble fibrin CPM = 236	(141 - 320)			312								172
Keflin® IV	every 4 hrs.	begun							disc. 2/19			
Keflex® 50	0 mg every 6 hrs. by	y mouth							begun		disc. 3/1	
Heparin 50	00 units every 4 hrs			begun					disc.			
Packed R Whole bl	Blood Products BC, units ood, units ipitate (packs)			2		4 10						

is of common occurrence. Three cases of influenzal pneumonia were reported by Talley and Assumpca.¹⁸ In one, fibrinogen and platelets were depressed suggesting DIC. No clotting studies were performed on the second patient. In the third, a single determination of fibrinogen and platelets were normal. Two were treated briefly with heparin. All three patients died.

By far the largest series of patients with influenza and coagulation disorders were reported in the Russian literature by Koval'chuk, et al, ¹⁹ who presented a series of 87 patients with A₂ or B influenza diagnosed serologically with antibody titer and/or culture. The coagulation mechanism was followed with the thromboelastogram rather than by conventional methods. They found that a large percentage of the patients showed a delay in intrinsic thromboplastin generation (first stage of clotting) and a delay in fibrinogen-fibrin conversion. Prothrombin consumption likewise was abnormal. However, absolute values for fibrinogen, platelets, clotting factors, and fibrin split products were not determined so that direct comparison with the present case is difficult.

Summary

A patient is described with documented influenza of the English type associated with the classic findings of disseminated intravascular coagulation. With antibiotic therapy plus heparin, the patient made an uneventful recovery. A search of the literature revealed a paucity of such reports in the English literature. Since influenza is a common occurrence, disseminated intravascular coagulation should be sought for more diligently in such patients.

Acknowledgments: Gilbert Schiff, M.D., Director of Infectious Disease Department, Cincinnati General Hospital, isolated and identified the influenza virus affecting this patient.

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(Continued on page 547)

Pressure Pulse Velocity Measurement: An Index of Thyroid Function

Jack Marks, M.D.

The Q-Kd, defined by Rodbard as the interval between the Q wave of the EKG signal and the Korotkoff sound recorded at diastolic pressure at the antecubital fossa, has proved to be a useful indicator of thyroid function.

NEW KNOWLEDGE of normal and abnormal thyroid physiology is accompanied by an ever-increasing number of tests for the assessment of thyroid function. Even so, it is often difficult for the physician to be quite certain about some patients with borderline or early manifestations of thyroid disease.

The comments of Low-Beer¹ seem as valid today as when he made them in 1953:

"Radioactive uptake studies are very valuable, however, in clinically clear-cut cases of hyper or hypothyroidism, we really do not need this study. We need a method for that small group of borderline cases in which we always have a problem of reaching a decision, whether we are dealing with true hyper or hypothyroid states . . ."

The physician's diagnosis is formulated in large part by the data supplied by the laboratory. Despite a seeming plethora of newer laboratory techniques for the assessment of thyroid function, the clinician remains as much as ever in need of reliable objective methods for assessing thyroid function. As a matter of fact, it seems his problems are sometimes compounded by the contradictions of one laboratory test with another. The widespread use of progestins and the ubiquity of iodinated drugs and iodinated x-ray contrast media have further complicated the diagnosis of thyroid disorders.

Methods of Thyroid Study

For the most part, the present methods of thyroid study involve measurement of the thyroid gland's capacity to trap radioactive isotopes of iodine (and more recently technetium 99^m) and in quantitating the circulating thyroid hormones and/or their binding to specific serum proteins.

There are, however, other methods of assessing function of the thyroid gland. The consumption of oxygen in a unit of time (the basal metabolic rate) now used less than formerly, represents a well-known index of thyroid function. The relaxation time of various tendons after stimulation (most popularly the Achilles tendon), also reflects the status of the thyroid gland. However, this type of test fails to clearly discriminate many patients because of substantial regions of overlap.

Now, more and more being appreciated, is that the assessment of the kinetics of the cardiovascular system provides indices of thyroid function.

It has long been known that the character of myocardial contractility is distinct in abnormalities of thyroid function. This is particularly true of hyperthyroidism, as recently restated by Cooley and Schreiber: ". . . at fluoroscopy, the heart is seen to be exceedingly active and the ventricular pulsations are increased in amplitude. Often,

Dr. Marks, Columbus, Active Staff, Grant and St. Ann's Hospitals; Courtesy Staff, The Ohio State University Hospitals; and Assistant Clinical Professor of Medicine, The Ohio State University College of Medicine. Submitted November 6, 1974

there is quite rapid, somewhat jerky or snappy inward excursion of the left ventricle during systole . . ."²

Amidi, et al³ have measured the ejection intervals in normal patients and in those with hypothyroidism and hyperthyroidism. When correction was made for the pulse rate and cardiac output (employing the regression formula of Weissler and co-workers⁴), it was shown that the pre-ejection period in hyperthyroid subjects is shorter, and in hypothyroid subjects is longer than in normal persons.

Parisi, et al recently published the results of their study, also employing systolic time intervals.⁵ Their work also demonstrated the shortening of the preejection period in hyperthyroidism and the lengthening of the preejection period in hypothyroidism as compared with normals.

These studies appear to have much to recommend them in terms of their diagnostic specificity. However, the instrumentation necessary to perform such evaluation would seem to limit the usefulness of this method for those physicians who have well-equipped laboratories and the availability of relatively skilled assistants.

Rodbard, Fujita, and Rodbard⁶ have described a technique for the diagnosis of thyroid state which measured the intervals of time between the onset of the QRS complex of the electrocardiogram and the Korotkoff arterial sound recorded at the antecubital fossa. They describe their method as follows:

"With the patient reclining on an examining table, a standard blood pressure cuff is placed on the upper arm and a microphone is placed over the brachial artery immediately distal to the cuff. Electrocardiographic electrodes, for standard limb lead I or II, are placed on the patient. The blood pressure is inflated to the level above systolic pressure and then deflated at approximately two millimeters mercury per second. The Korotkoff sounds appear as the cuff pressure falls between systolic and diastolic and these sounds are detected by the microphone, electronically amplified, filtered (band-pass, 140 to 240 cps.) and recorded simultaneously with the electrocardiogram on a two-channel oscillograph with a recording paper speed of 100 millimeters per second."

The "Q-K interval," thus determined, is the interval between the onset of the QRS complex and onset of the Korotkoff arterial sounds. These authors designate this interval as the Q-Kd when the cuff pressure is at diastolic pressure. Their data indicates significant differences in normal, hypothyroid, and hyperthyroid patients (Table 1).

I have employed this test but modified it from the description of these authors, in that I used a single-channel

Table 1. Standard Deviation in "Q-K Interval" in Normal, Hypothyroid, and Hyperthyroid Patients as Recorded by Rodbard, et al⁶

Diagnostic Group	No. of Patients	Mean Q-Kd (msec)	Standard Deviation
Hyperthyroid	37	152	15
Normal	80	211	12
Hypothyroid	10	282	27



Recording the onset of QRS complex and Korotkoff arterial sounds.

(Cambridge Model VSIII(TM)) EKG recorder superimposing the Korotkoff sounds upon the EKG signal with a Cambridge Audeo-Visual Heart Sound Recorder-(Model AVR 855(TM)) through a mixer (Cambridge Model 1-659(TM)). No filter of the Korotkoff sounds was employed. Recordings of these events were made at a paper speed of 50 millimeters per second. Measurements were made to the nearest 5 milliseconds. More recently, I have employed the Lumiscribe(TM) Model RS-200 S, two-channel, phonocardiographic instrument employing the supplied crystal microphone, Model MP 1A. The Korotkoff sounds have been filtered at the midband pass filter (120-500 Hertz) as shown in the figure. By and large, my observations have been similar to those reported by Rodbard, et al⁶ and are shown in Table 2.

In the hyperthyroid population, the 95 percent confidence limit was from 129.4 to 194.2 msec. (\pm 2 S.D. of mean) In the euthyroid (normal functioning) population, the 95 percent confidence limit was from 186.2 to 239.8 msec. (\pm 2 S.D. of mean). In the hypothyroid population, the 95 percent confidence limit was from 196.8 to 326.2 msec. (\pm 2 S.D. of mean). All population groups were limited to patients under 50 years of age, without intraventricular conduction disturbances in their EKGs and without other known evidence of heart disease.

Discussion

With each cardiac contraction, a pressure pulse is transmitted throughout the vascular tree. This pulse wave travels much more rapidly than does the bolus of blood whose ejection initiated the wave.

The pressure pulse wave velocity in the aorta is 3 to 5 meters per second. In the large arterial branches, it is about 7 to 10 meters per second, and 15 to 35 meters per second in small arteries. The mean blood flow in the aorta, however, travels at a rate of only about 0.5 meters per second.⁸

The velocity of the pressure pulse propagation is influenced by the mobilization of ventricular tension, $(\frac{dp}{dt})$, coordination of atrial and ventricular contraction ("atrial kick"), the sequence of intraventricular contraction, cardiac output, compliance of the vascular tree and peripheral resistance.⁶⁻⁹

Rodbard, et al⁹ had divided the early events of ventricular activation and ejection into two phases. They termed the interval from the onset of the EKG, (the Q wave) until the onset of ejection (E) at the aortic valve, the "Q-E time," and they termed the time required for the transmission of the pulse wave from the aortic valve to the point of Korotkoff sound production at the sphygmomanometer cuff the "E-K time."

In the more recent literature, the "Q-E time" has been considered in the context of the systolic time intervals and would seem to correspond to the preejection period (PEP).⁴

The Q-K time interval is affected by a variety of influences involving the myocardium and arterial vasculature. It has been shown to be increased in valvular aortic stenosis, left bundle-branch block, by halothane anesthesia and beta-adrenergic blockade with propranalol. The Q-K interval is decreased in idiopathic hypertrophic subvalvular aortic stenosis by the administration of epinephrine, phenylephrine, calcium ion in general arteriosclerosis, and, of course, in thyrotoxicosis, 6,9,11

DeGroot and Leonard¹² have recently discussed the circulatory manifestations of thyrotoxicosis. These authors note that some changes of hyperthyroidism are mediated through the sympatho-adrenal medullary system. Betaadrenergic blockade with propranalol has had a very salutory effect upon the clinical manifestations of hyperthyroidism. However, reversal of the abnormal circulatory dynamics of hyperthyroidism has not been achieved by beta-adrenergic blockade. Cardiac output has not been significantly affected by depleting catechol reserves with reserpine or with large does of guanethidine. The increase of cardiac output and associated vasodilitation in hyperthyroidism is caused by direct influence of the thyroid hormones upon the cariovascular system through littleunderstood mechanisms. Hypothyroidism, of course, produces opposite effects.

Toole and Tulloch¹³ have described differences in the blood pressure and differences in the arrival time of the arterial pulses in the two upper extremities in subclavian steal syndrome as determined by two electronic sphygmomanometers connected by a common pressure system. Rahman and Rodbard,¹⁴ through the use of their instrument termed a "sphygmorecorder," have also demonstrated differences in the parabolic pressure fronts of the

TABLE 2. Standard Deviation in "Q-K Interval" in Hyperthyroid, Euthyroid, and Hypothyroid Patients as Recorded by Author

Diagnostic Group	No. of Patients	Mean Q-Kd (msec)	Standard Deviation
Hyperthyroid	20	161.8	16.2
Euthyroid	40	208.0	10.9
Hypothyroid	12	255.4	30.4

two pulses of the upper extremities in the subclavian steal syndrome. Thus, obstruction of the subclavian and brachial arteries are readily sensed by differential sphygmomanometry as well as by measurement of the arterial pressure pulse arrival times.

Tavel, et al¹⁵ have shown that the Korotkoff sound emanates from immediately below the lower edge of the sphygmomanometer cuff. Therefore, this would be the preferred site for microphone placement in performing this type of study.

Weissler, et al¹⁰ derived regression data for the preejection period, relative to varying heart rates, in a series of 121 normal men and 90 normal women with an age range from 19 to 65 years. In summing up their data, the mean preejection period for all of these normal subjects was .098 seconds (98 milliseconds). In most individuals, the distance from aortic root to brachial artery at the elbow is approximately 40 centimeters.¹⁴ Therefore, if nearly 100 milliseconds are consumed from the initiation of the Q wave to the ejection of the arterial pulse wave across the aortic valve (PEP), approximately 110 milliseconds would be occupied for the propagation of the pulse wave over the 40 cm of aorta, subclavian, and brachial arteries to the antecubital fossa. This, therefore, represents a pressure pulse velocity of approximately 0.36 cm/millisecond through these arteries in normal individuals.

Variations of the PEP would preclude aortic valve to antecubital fossa pulse velocity determination by measurement of the Q-Kd interval alone. And considerable non-homogeneity would be introduced if the data published by Rodbard were applied to small children or individuals whose aortic valve to antecubital fossa varied greatly from 40 centimeters. Nevertheless, it probably would be useful to construct a table of normal Q-Kd times for different age groups since generalized arteriosclerosis, with its alteration of arterial wall compliance, has proved a limiting factor in application of this technique in testing the aged. For that reason, our data was compiled from individuals younger than 50 years of age.

Conclusion

After nearly seven years of use, I believe the measurement of the Q-Kd, as defined by Rodbard and his coworkers, is very useful in the day-to-day study of patients suspected of having thyroid disease. It correlates reasonably well with other established measurements of thyroid function. It does not require the administration of radionuclides and is not affected by exogenous iodides or variations in the thyroid-binding proteins. It is relatively simple and inexpensive and the results are immediately available for analysis.

Acknowledgements: This paper was reviewed by Robert Hamlin. DVM, Ph.D.; and the photograph was made by Stuart

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Avascular Necrosis of the Femoral Head in the Adult

Thomas H. Mallory, M.D.

Avascular necrosis is segmental ischemia of the femoral head involving all or a portion of the weight-bearing surface. There is subsequent collapse, and eventual degenerative arthritis which leads to serious end-stage destruction of the joint. Although the leading cause is fracture of the cervical neck, avascular necrosis is the manifestation of many systemic diseases. The relationship between alcoholism, osteoporosis, and avascular necrosis is apparent, but is still undefined.

The diagnosis of avascular necrosis is based on symptoms and changes shown on x-ray films. Initially, the diagnosis may be very difficult, but as progression occurs, the condition becomes obvious. Treatment is geared toward stage of involvement. In the initial stages, weight protection can lead to the recovery of this condition. However, once there has been collapse of the femoral head, surgical intervention is necessary. This may involve bone grafting, replacement of the femoral head, or total hip replacement.

INTERRUPTION OF THE BLOOD SUPPLY to the femoral head in the adult can lead to avascular necrosis. This condition has long been recognized but poorly understood. It now is obvious that avascular necrosis is associated with many different diseases.¹

The pathologic process of this disease originally was thought to result from focal ischemia of end-arteries that supply the weight-bearing portion of the femoral head.² The usual segmental involvement consists of a wedge-shaped area in the anterior lateral weight-bearing portion of the femoral head and neck.

Initially, the cartilage remains intact, presumably nourished by the synovial fluid. Beneath the intact carti-

lage, there is subchondral necrosis which is subject to stress fracture and subsequent collapse. When the articulating cartilage is no longer supported, it is subject to injury and degeneration. Progressive deterioration of the entire hip joint will follow once cartilage collapse has occurred.³

Etiology

Etiologic causes of avascular necrosis of the femoral head are numerous. The leading causes are fractures of the cervical neck of the femur, particularly where there has been marked displacement or inadequate reduction.4 Other causes of avascular necrosis include traumatic dislocation of the hip joint, sickle cell anemia, hemolytic anemia, lupus erythematosus, occlusive vascular disease, pheochromocytoma, infection, radiation osteitis, Gaucher's disease, Kashin-Beck disease, pregnancy, Charcot's disease, Fabry's disease, coagulation deficiency, Leriche's syndrome, and tumor processes, especially fibrosarcoma. In addition, avascular necrosis may be found in rheumatoid arthritis in approximately 5 percent of the patient population regardless of whether or not steroid medications have been used.³ Renal transplantation patients are subject to avascular necrosis, especially when large doses of steroid and immunosuppressive drugs have been used for prolonged periods.5

There may be a drug-induced avascular necrosis secondary to the use of steroids as well as other anti-inflammatory agents such as Butazolidin® and Indocin.®

Perhaps the most interesting phenomenon of avascular necrosis is the so-called idiopathic condition in which no systemic disease or associated drug therapy has lead to the development of this disease entity. These patients are usually middle-aged male adults between 40 and 60 years of age who have noted a gradual and insidious onset of hip pain. The interval between symptoms and

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Submitted October 31, 1974.

the establishment of the diagnosis by x-ray may vary from one month to ten years. It appears more in males than in females, with a ratio of approximately four to one. The disease appears bilaterally in 40 to 60 percent of the cases. Interruption of the blood supply is felt to be the initial insult to the femoral head, but how this occurs remains unknown. Theories have ranged from sepsis to avascular occlusion, fat emboli, and/or venous obstruction. The final answer is still to be found. There is a very interesting relationship between alcoholism and the incidence of idiopathic avascular necrosis. Liver disease has been proven in as high as 80 percent of these patients. It has been speculated that showers of fat emboli are released from the liver which produce obstruction to the blood supply to the femoral head.

Solomon and associates have recently published an interesting concept in which is stated the condition of avascular necrosis of the femoral head is a result of generalized osteoporosis, which seems to be the very nature of many of the clinical disorders manifested in this phenomenon.6 The osteoporotic portion of the femoral head is subject to large forces which are dissipated across this area during weight bearing. In the presence of osteoporosis, there is subsequent collapse of supporting subchondral bone which results in necrosis and, finally, cartilage damage and subsequent degenerating phenomenon. Many patients are given high doses of steriods and analgesic-type agents initially for the relief of discomfort. The analgesic effect of these agents may allow the patient comfortable weight bearing, but this does irrevocable damage to the weight-bearing portion of the femoral head.

Treatment

Treatment of this interesting condition can be divided into three stages. Stage 1 involves clinical manifestation prior to femoral head collapse. These patients complain of intermittent groin and midthigh pain especially with weight bearing. Physical examination will reveal that the individual has a normal range of motion, but does experience pain with internal rotation and with straight-leg lifts. X-ray films often are interpreted as normal, however, critical evaluation may reveal the characteristic wedgeshaped bone density developing in the weight-bearing pertion of the femoral head (Fig. 1). It certainly is important at this point to protect the patient from full weight bearing. The patient should be placed on crutches, and a weight-reduction program and range-of-motion exercises should be offered to him. His complaints of pain should be treated with mild analgesic agents. Based on the possibility of reavascularization and support of the ischemic bone, the area of avascular necrosis will heal in 20 percent of these patients.1

Stage 2 involves collapse of the femoral head without acetabular involvement (Fig. 2). The patient is now in the surgical phase of his disease. Femoral head replacement with the Austin Moore prosthesis is indicated. Additional surgical procedures available at this point in the disease involve osteotomy with rotation of the femoral

head to provide healthy bone in the area of weight bearing.

Stage 3 involves complete collapse of the femoral head with associated acetabular involvement (Fig. 3). Therefore, the disease involves both components of the hip joint, and the logical surgical solution to this problem is total hip replacement.

Summary

Avascular necrosis of the femoral head is a common disease entity which is a manifestation of many etiologic processes. Pathogenesis generally involves focal ischemia with associated osteoporosis. Continuous weight bearing across the involved femoral head results in femoral collapse with subsequent acetabular involvement and, finally, end-stage degenerative arthritis.

Early treatment consists of recognition and institution of weight protection. In the latter stages, surgical intervention is necessary.

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Fig. 1. Avascular necrosis (stage 1). Note wedge-shaped opacity in weight-bearing dome.



Fig. 2. Avascular necrosis (stage 2). Femoral head has collapsed but acetabulum remains intact.

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Fig. 3. Acetabular involvement with end-stage degenerative arthritis (stage 3).

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AMA Elects New Officers, Raises Membership Dues

Effective January 1, 1976, AMA dues for regular members will be \$250. Residents and interns will pay \$35. Student dues will remain at \$15. The AMA House of Delegates voted in favor of the dues increase during the

Annual Convention at Atlantic City.

The House of Delegates elected new officers as follows: President-Elect—Richard E. Palmer, M.D. of Virginia; Vice-President—George W. Slagle, M.D. of Michigan; Vice-Speaker of the House—William Y. Rial, M.D. of Pennsylvania; Board of Trustees Members—Lowell S. Steen, M.D. of Highland, Indiana; Jere W. Annis, M.D. of Florida; Robert B. Hunter, M.D. of Washington; Joe T. Nelson, M.D. of Texas; Joseph F. Boyle, M.D. of California.

Other actions taken by the House of Delegates included:

- The AMA is henceforth to have a balanced budget with no further deficit spending. All resolutions before the House, as well as reports from the Board of Trustees, and Councils and Committees, must henceforth carry a fiscal note.
- The House of Delegates recommended to the Board of Trustees that JAMA and American Medical News receive resources to keep them at highest levels and that PRISM be discontinued. All publications except JAMA and American Medical News will be placed on a subscription basis for members. Today's Health was removed as a membership benefit.

• The AMA Board Utilization Review Suit was sup-

ported by the House.

• The Board of Trustees was authorized to form a "reinsurance company" to support professional liability

insurance programs.

• The Council on Long Range Planning and Development was requested by the House to study possible reorganization of the AMA, its House, Board of Trustees, Council and Committees and other activities in keeping with sound business methods, socio-economic trends and AMA stated objectives. Results of the study will be reported at the 1975 Clinical Session.

Five resolutions proposed by the Ohio Delegation

were considered by the House:

• A resolution requesting that AMA hold itself scrupulously apart from the activities of AMPAC with regard to staff and physical location was filed with the House.

 A Substitute Resolution was passed stating that the AMA should seek representation by physicians in active non-governmental practice on the Privacy Act Commission and any other agencies or governmental task forces studying confidentiality of medical records so that there may be input from the medical profession to such commissions, agencies, and task forces.

• The House passed a resolution proposing that the present Board of Trustees be commended for its efforts to curtail AMA expenditures. The resolution also requested the Board of Trustees to convey to the membership the necessity of continued financial support from

individual physicians.

• An amended resolution was adopted expressing concern that the Catholic Hospital Association's recently issued guidelines on patient care could have detrimental effects. The AMA suggested revising the guidelines to confirm the status of physician members of the medical staff organization as independent practitioners in their relationships to their patients. Revisions establishing direct lines of communication between physicians and the governing body in the policy and decision making processes of the institution were also recommended.

• The House resolved that AMA members should continue to be informed of the undesirable effects of HEW Regulations in regard to Utilization Review under the Social Security Act. The AMA will continue to take appropriate action to protect the constitutional rights of patients and physicians. Physicians were asked to continue performing peer review through their various hospital medical staff committees in order to increase the quality of patient care and reduce its cost.

In his inaugural address to the House of Delegates, President Max H. Parrott, M.D., recommended that the offices of AMA vice president, president-elect, and immediate past president be abolished. He further recommended that the Speaker and Vice Speaker of the House of Delegates be given votes on the Board of Trustees and that the Chairman of the Board be elected directly by the House of Delegates after nomination by the Board

of Trustees

The following gifts were presented to AMA-ERF:
American Medical Association Auxiliary \$1,361,564
The AMA Fifty Year Club 5,000
The Audio Digest Foundation of the

California Medical Association 50,000 AMA-ERF Vice President John Budd, M.D. (Ohio) noted that the foundation has over the years guaranteed 55,199 loans totalling \$64,108,298. He called this "an outstanding display of professional responsibility and confidence in the future of our profession."

(More News on next page)

Two Students Win OSMA's 1975 Family Practice Scholarships

Recipients of OSMA's 1975 Thomas E. Rardin Family Practice Scholarships of \$2,000 each are Aaron R. Folsom of near Bellefontaine and Thomas G. Trautmann of Cincinnati. They were selected from among 48 candidates who have been accepted by medical schools following completion of their pre-medical education.

This year marked the 27th annual awarding of the scholarships, designed to encourage young men and women residents of Ohio to become family physicians in Ohio.

The two winning candidates were selected in competition based on character, integrity, intelligence, mature personality, need, interest in community life, leadership, scholastic ability, and interest in becoming a family physician.



Aaron R. Folsom



Thomas G. Trautmann

Folsom will enter The Ohio State University College of Medicine in July. Trautmann will begin his medical studies in the fall at the University of Cincinnati College of Medicine.

Following graduation from Benjamin Logan High School as valedictorian of his class in 1971, Folsom attended Capital University, Columbus. He recently completed his pre-medical studies there. Along with a high ranking in scholarship, Folsom also was an outstanding participant in track and cross country at Capital. He established school records in the four and five-mile cross country events and two, three and six-mile track events. He was 1975 Ohio Conference champion in the indoor

two-mile run and the three-mile event.

Trautmann attended Xavier University, following graduation from St. Xavier High School, Cincinnati in 1971. He recently completed his pre-medical studies at Xavier as valedictorian of his 280-member graduating class. Trautmann was recipient of the Xavier Biology Award for superior achievement in scholarship, research and co-curricular activities.

For three years Trautmann has worked part-time as a physical education teacher, athletic coach and recreation instructor at St. Aloysius Orphanage. He has also worked as an operating room technician at Providence Hospital.

Four other medical students are currently receiving the Thomas E. Rardin Family Practice Scholarship: Phyllis Anne Hutson of East Cleveland (Case Western Reserve University School of Medicine); Donald J. Kennedy, Cincinnati (University of Cincinnati College of Medicine); Gayle Anne Galan, Cleveland (Case Western Reserve University School of Medicine); and Michael Gaudiose, Youngstown (The Ohio State University College of Medicine).

Dr. Harding Awarded Honorary Degree

Frances Keller Harding, M.D., Columbus, a pastpresident of the American Medical Women's Association and a recipient of the Elizabeth Blackwell Award of Hobart College, was awarded an honorary Doctor of Humanities degree by Otterbein College, Westerville, June 12.

Ohio State Medical Association was named codefendant in a suit filed against Ohio Medical Indemnity, Inc. by Ohio Attorney-General William Brown on July 9, alleging that OSMA and OMI conspired to fix, raise and/or stablize fees and to monopolize various aspect of the health care industry in 83 Ohio counties. Suit was filed in the Federal District Court in Columbus.

The suit was considered during the July 12-13 meeting of The Council and James E. Pohlman, the Association's legal counsel, and the Columbus law firm of Wright, Harlor, Morris and Arnold were instructed to defend the case vigorously and to seek full vindication of the charges in Federal Court.

(More news on page 563)



FDA Holds Hearings On Oral Antidiabetic Drugs

The Food and Drug Administration (FDA) planned to hold hearings on August 2 on its proposed requirement that all containers of "Oral Antidiabetic Drugs" include a bold faced boxed statement: The administration of oral hypoglycemic drugs may be associated with increased cardiovascular mortality as compared to treatment with diet alone or diet plus insulin.

The controversial reports of the University Group Diabetes Program (UGDP) in 1971 and 1975 spurred

this action.

The FDA will further recommend that the oral drugs tolbutamide and phenformin be labeled to present recommendations to physicians that they prescribe diet as a preferred method of reducing blood sugar levels in diabetics. Physicians are recommended to use oral compounds only when symptoms can't be controlled by diet or by patients who refuse or are unable to take insulin.

Refer to page 229 of the Journal's April issue for an

editorial discussing reported UGDP findings.

Glaucoma Screening Involves Legal Responsibilities

Physicians involved in glaucoma screening programs should be aware of legal responsibilities involved. The Medical Advisory Committee of the Ohio Society for the Prevention of Blindness recently made the following comments:

"With the standard methods of glaucoma screening used in the past, requiring topical anesthetic and a tonometer on the eye, there is an inherent risk of corneal abrasion, reaction to the topical anesthetic, or spread of infection. Although these risks are minimal, they do exist.

Usually a VOLUNTEER conducting screenings, without pay, is covered by primary insurance of the National Society for the Prevention of Blindness, when the Society or one of its affiliates is sponsoring the screening. This insurance protection does not cover a resident, or any other individual, if he is being paid for his services. In this instance, he must provide his own.

Individuals on the payroll of an outside agency must also provide their own insurance. Individuals paid a fee by a sponsoring organization should be covered by the insurance of the sponsoring group.

The Medical Advisory Committee suggests that any

PHYSICIAN, prior to performing tonometry in a glaucoma screening program, obtain a written statement from the sponsoring organization that he is not receiving a fee but is volunteering his services. The physician should also obtain written confirmation of the liability responsibilities and coverage of the sponsoring organization.

The use of the non-contact tonometer completely eliminates the danger of abrasion and anesthetic reactions, as well as spread of infection. The Medical Advisory Committee feels this type of instrument is much more satisfactory for use in glaucoma screening programs. Choosing the Schiotz instrument is no longer advocated."

Physicians involved with residency programs are asked to share these comments with their residents. Any questions should be directed to the Ohio Society for the Prevention of Blindness, Suite 303, 1500 West Third Avenue, Columbus, 43212.

Natl. Board Of Medical Examiners Names Ohio Physician Chairman

Dr. John S. Millis, Chancellor Emeritus of Case Western Reserve University, has been named Chairman of the National Board of Medical Examiners (NBME).

Formed and supported by organizations in the areas of medical practice, licensure and education, NBME prepares, administers and scores a variety of examinations for physicians.

Results of examinations are used by state medical boards for licensure to practice medicine, by medical specialty boards for certification, by schools of medicine for determining student progress and by practicing physicians to measure their continuing progress.

The Board also conducts a research program in educational measurement and competency testing, in an effort to improve the quality and effectiveness of its examinations.

Dr. Millis also serves as Chairman of the National Fund for Medical Education, in which he has held several positions since his retirement from CWRU in 1969.

He is currently Chairman of the Study Commission on Pharmacy commissioned by the American Association of Colleges of Pharmacy, and Consultant to the Director of the National Institute of Dental Research.

He is a trustee of CWRU, the American Nurses' Foundation and the Musical Arts Association.



Dr. Mattmiller Becomes Ohio U.'s Vice President

An OSMA member has been appointed acting vice president for academic services at Ohio University, Athens. E. Dale Mattmiller, M.D. is director of the Ohio University Unified Health Services.

As acting vice president, Dr. Mattmiller will handle several areas of academic services in addition to health services. His new responsibilities include admissions, Alden Library, placement and internship services, registration and student records, student financial aids, student life programs, and university judiciaries.

Dr. Mattmiller joined Ohio University's health services in 1963 and was named director in 1964. He is also an associate professor in the Department of Health, Physical Education and Recreation, and is the associate athletic team physician. He has stated that he will not be a candidate for the vice presidential position on a permanent basis.

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Physician Joins News Team Of Cleveland TV Station

Cleveland's WEWS TV-5 news team has a different angle on local medical news and national medical news with local impact. One of its commentators is a physi-

Theodore J. Castele, M.D., Past President of the Academy of Medicine of Cleveland, appears when news is breaking on medical subjects. He is involved in news gathering as well as the live news broadcasts. Dr. Castele is the first physician to serve in such a capacity in the Cleveland area.

When subject matter extends beyond Dr. Castele's area of expertise, he relies on the Academy's information sources to obtain comments from specialists in a particular

Dr. Castele thinks his participation is "... a wonderful opportunity to provide accurate, authoritative information on health subjects."

Columbus Physician Reelected President Of Ohio Heart Assn.

Jack S. Silberstein, M.D., Columbus, was re-elected President of the Ohio Affiliate, American Heart Association at its recent meeting. William H. Bunn, Jr., M.D., Youngstown, was made President-Elect.

Other officers elected and the Executive Committee are as follows: Jacob F. Hess, Jr., Canton, Chairman of the Board; Simon Koletsky, M.D., Cleveland, Secretary; John S. Andrews, Youngstown, Treasurer; Fred B. Miller, Columbus, Assistant Treasurer; Thomas A. Bittenbender, Cincinnati; Albert A. Brust, M.D., Dayton; Robert E. Roy, M.D., Ravenna; Frank G. Love, Lima; George T. Parry, Akron; Ralph D. Lach, M.D., Columbus; Robert H. McMaster, M.D., Cincinnati; and J. Lester Kobacker, M.D., Toledo, Medical Representative to the North Central Region.

OSU Professor Presents Seminars In Great Britain

Selected as the 1975 James IV Society Surgical Traveling Fellow to Great Britain was John Peter Minton, M.D., Ph.D. Dr. Minton is Associate Professor of General Surgery and Cancer Coordinator at Ohio State University's Department of Surgery.

As part of his formal itinerary, Dr. Minton presented cancer related seminars at 15 medical facilities in England and Scotland.

Ohio Prison Inmates Receive Only "Crisis" Medical Care

Medical care systems in Ohio jails and prisons appear to be geared mainly toward dealing with problems only after they have occurred. Almost no attention is paid to preventive medicine, and special facilities are rarely provided for treating alcoholism, mental illness, and drug abuse. Similar conditions seem to prevail throughout the United States.

These conclusions were drawn by OSMA's Committee on Medical Care in Prisons and Jails. Appointed in 1974, the ten-member committee surveyed Ohio county jails and collated data concerning Ohio from the American Medical Association's book *Medical Care in U.S. Jails.* The book gives results from a national survey conducted by the AMA in 1972.

The following charts present information selected by OSMA's Committee from both the national and local surveys.

SUMMARY OF SURVEY RESPONSES

	Sample Population	Number of Responses	Percent Responses
AMA Survey	2930	1159	39.6%
Ohio County Survey	88	53	60.2%
Ohio City Survey	99	50	50.0%

EXPLANATION: Both the Ohio county and city surveys had a higher percentage response than the national AMA survey. The Ohio county jails surveyed gave the best response. In order to find a standard percentage for each survey, the percentages are always based on the number of total respondents to the survey and not the number of respondents to any particular questions. Since most respondents answered more than one question affirmatively, the percentages in the tables do not add total 100.

SOURCES OF MEDICAL CARE

	National Jails	Ohio County Jails	Ohio City Jails
Physicians' offices Government	62.6%	73.6%	20%
hospitals Private	47.5%	43.7%	28%
hospitals	41.8%	52.8%	76%

In the county jails, special arrangements are being made with private physicians willing to care for inmates, while in the cities, as might be expected, hospitals are being looked to as the source of primary care. Very few institutions provide their own comprehensive health services

MEDICAL PERSONNEL AVAILABLE

DI	National Jails	Ohio County Jails	Ohio City Jails
Physicians Availa	ble		
Regular Basis	38.0%	20.8%	14%
Physicians Availa	ble		
On Call Basis	50.6%	71.7%	40%
Physicians Called		, ,	/ -
		70.00	710
As Needed	77.8%	73.6%	74%

Respondents indicated that medical personnel in jails were available usually only to manage emergency needs.

REIMBURSEMENT OF PHYSICIANS

Fee-for-service	National	Ohio County	Ohio City
	Jails	Jails	Jails
basis	72.8%	71.7%	73.6%
Salary basis	23.5%	24.5%	18.0%

Reimbursement of physicians is primarily on a feefor-service basis.

OTHER PERSONNEL AVAILABLE

	National Jails	Ohio County Jails	Ohio City Jails
Dentists		ŭ	
Available	37.8%	56.6%	
Nurses			
Available	18.6%	17.0%	18%
Social Workers			
Available	21.1%	11.3%	6%
Psychologists			
Available	15.2%	15.1%	6%

Other health care workers, although by no means less regularly needed, were even less regularly available.

FACILITIES IN JAILS

National Jails	Ohio County Jails	Ohio City Jails
65.5%	67.3%	66%
16.7%	22.6%	14%
17.4%	13.2%	12%
13.1%	9.4%	*
		/
9.1%	9.4%	6%
		Jails Jails 65.5% 67.3% 16.7% 22.6% 17.4% 13.2% 13.1% 9.4%

Facilities are usually provided for only the more superficial kinds of crisis management. While alcoholism, mental illness, and drug abuse are certainly not unusual complications of incarceration, special facilities for their management are seldom provided.

(continued on next page)

Ohio Prisons /continued

COMPARATIVE EVALUATION OF HEALTH CARE IN OHIO

Physicians are available on a regular basis in Ohio only about half as frequently as they are nationally. Dentists are somewhat more available. Availability of nurses and psychologists is almost the same as the national figure. Social workers are less than half as frequently available. Special facilities for drug abusers are about equally rare in Ohio as in the national statistics, although the national figures are better for the alcoholic and the mentally ill.

SERVICES PROVIDED TO INMATES

	National Jails	Ohio County Jails	Ohio City Jails
Prescription	•	_	-
Drugs Dispensed	97.8%	98.1%	78%
Drugs Dispensed			
by non-medical			
personnel	81.6%	67.9%	74%
1			1 6 1

When the staff is aware of prescriptive needs of inmates, these are usually adequately provided.

SANITARY INSPECTIONS

	National Jails	Ohio County Jails	Ohio City Jails
Sanitary inspection on regular basis Inspections on	87.3%	88.7%	98%
monthly basis or more frequently	49%	47.2%	76%

All survey groups paid fairly careful attention to sanitation.

SUMMARY

Although such limited and superficial data is implicitly general and probably of minimal help to those who deal directly with these problems on a day-to-day basis, some conclusions were drawn.

The health care system does appear to suffer from a lack of uniform standards and goals. It seems geared to deal primarily with problems after they have occurred. There is almost no attention paid to preventive medicine, and the special problems commonly presented by inmates are neither anticipated nor dealt with specifically.

Ohio might benefit economically and socially if those medical and paramedical techniques available to the general community were applied to inmates. Particularly useful might be techniques directed toward prevention, early detection and treatment, and rehabilitation.

OSMA's Committee on Medical Care in Prisons and Jails is evaluating possible recommendations and solutions.



Pro-Banthine®

brand of propantheline bromide

Indications: Pro-Banthīne is effective as adjunctive therapy in the treatment of peptic ulcer. Dosage must be adjusted to the individual.

Contraindications: Glaucoma, obstructive disease of the gastrointestinal tract, obstructive uropathy, intestinal atony, toxic megacolon, hiatal hernia associated with reflux esophagitis, or unstable cardiovascular adjustment in acute hemorrhage.

Warnings: Patients with severe cardiac disease should be given this medication with caution. Fever and possibly heat stroke may occur due to anhidrosis.

Overdosage may cause a curare-like action, with loss of voluntary muscle control. For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted. Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthīne.

Precautions: Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

Dosage and Administration: The recommended daily dosage for adult oral therapy is one 15-mg, tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

How Supplied: Pro-Banthīne is supplied as tablets of 15 and 7.5 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg.

SEARLE

Searle & Co. San Juan, Puerto Rico 00936

Address medical inquiries to: G. D. Searle & Co. Medical Department, Box 5110, Chicago, III. 60680 481

main purpose of drug information for the patient is to get his cooperation in following a drug regimen.

Preparation and distribution of patient drug information

We would hope to amass information from physicians, medical societies, the pharmaceutical industry and centers of medical learning. The ultimate responsibility for uniform labeling must, however, rest with the Food and Drug Administration. There is nothing wrong with this agency saying, "this information is generally agreed upon and therefore it should be used," as long as our process for getting the information is sound.

Distribution of the information is a problem. In great measure it would depend on the medication in question. For example, in the case of an injectable long-acting progesterone, we would think it mandatory to issue two separate leaflets—a short one for the patient to read before getting the first shot and a long one to take home in order to make a decision about continuing therapy. In this case, the information might be put directly on the package and not removable at all. But for a medication like an antihistamine this information might be issued separately, thus giving the physician the option of distribution. This could preserve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

Realistic problems must be considered

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chemical and such types of material should not be included. And there is

no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

Only the doctor can remove that fear by 20 or 30 minutes of conversation.

I'm not suggesting that we withhold any information from the patient because, first of all, it would be totally dishonest and secondly, it would defeat the very purpose of the insert. I do think that a patient on the birth control pill should know about the incidence of phlebothrombosis.

If you're going to tell a patient the incidence of serious adverse reactions, then you have to tell him that a concerned medical decision was made to use a particular medication in his situation after careful consideration of the incidence of complications or side effects.

Emotionally unstable patients pose a special problem

There are patients who, because of severe emotional problems, could not handle the information contained in a patient package insert. Yet if we are going to have a package insert at all, we just can't have two inserts. I think we might simply have to tell the families of these patients to remove the insert from the package.

Legal implications of the patient package insert

Just what effect would a pa-

tient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

How do we handle an insert for medication used for a placebo effect?

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

Preparation of the package insert

The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

Pharmaceutical Manufacturers Association 1155 Fifteenth Street, N.W. Washington, D.C. 20005





the federal scene

The unusual one-day "public oversight" hearings in June by the House Ways and Means Committee's Health Subcommittee to determine if the Department of Health, Education and Welfare is superseding Congressional intent in an increasing number of Medicare cost-control regulations was marked throughout by angry confrontation between the HEW Secretary and health providers.

Undaunted by a solid array of heated opposition from medical and hospital groups, Secretary Caspar Weinberger told the Subcommittee that the four disputed Medicare regulations will save about \$250 million a year and "improve the quality of care."

The hearing bringing together Weinberger and his critics was called by Subcommittee Chairman Dan Rostenkowski (D-III.) who said he was sorry the confrontation had to take place. "I hope the Subcommittee can remove roadblocks. We should really try to get the government and the health care industry out of the courtroom and into the conference room where the debate belongs."

Four lawsuits have been filed against the HEW Department to overturn the regulations. Members of hospital and physicians' groups including the American Medical Association, urged the lawmakers at the hearing to crack down on HEW for going beyond the intent of law. But there was little indication from the Subcommittee that any swift action is contemplated.

Weinberger, easily fielding most of the Subcommittee's questions, refused to acknowledge any merit in the private sector's slashing attacks on the regulations, insisting the regulations followed the intent of Congress and were needed to curb costs. He suggested the remedy would be in seeking to have Congress change the laws, rather than in suing HEW.

The regulations under fire:

*Social Security's Utilization Review (UR) final regulations requiring elaborate institutional post admission review mechanisms.

*Reducing the schedule of limits on hospital inpatient general routine service costs from the 90th to the 80th percentile.

*Limitation on recognition of physicians' prevailing charge increases, based on an economic index.

*Termination of the inpatient routine nursing salary cost differential.

Stressing a common theme among the witnesses, the AMA cited "a general feeling of futility concerning administrative action felt by the public as a whole, but

especially by groups subject to and particularly affected by federal regulation." Ernest T. Livingstone, M.D., Chairman of the AMA Council on Legislation, said many professional associates display "an attitude often of exasperation, consternation and indignation with respect to the bureaucratic administration of government programs.

"Administrative regulations," Dr. Livingstone said, "often expand upon or subvert the intent of Congress." This is why, he explained, the AMA for the first time in its history recently sued the HEW Department, over the UR regulations. Federal Judge Julius Hoffman upheld the AMA's contentions and issued a restraining order against carrying out the UR rules. The HEW Department has recommended that the case be appealed.

A key AMA argument was that admission review within 24 hours is directed almost solely to protect hospitals against possible non-reimbursement—not the patient's health. Judge Hoffman said that if "patients who cannot pay cannot be hospitalized when diagnosis is unclear, the potential injury to the patient's health may be irreparable."

Edgar T. Beddingfield, M.D., Vice Chairman of the AMA Council on Legislation, said HEW barged ahead on the physicians' Medicare fee index without giving interested parties a chance to question the details of the regulations. There is no justification in either the law or its legislative history for imposition of a national economic index, Dr. Beddingfield told the panel, noting that Medicare fee recognition "has long lagged behind current trends in physicians' fees. Because of the unique two-year delay, he said the index limitations could result in shifting the financial burden to Medicare-Medicaid patients by driving reimbursement further below realistic fees.

Prepared by the Washington Office of the AMA.

House Passes Health Manpower

The Health Manpower Act (H.R. 5546) was passed by the House on July 11 with a margin of 296 to 59. Amendments supported by the AMA and American Association of Medical Colleges to limit the Department of Health, Education and Welfare's control of resident training were successful. Other amendments designed to prevent the federal government from collecting from medical students "capitation grants" made to medical schools were not accepted.

The bill now goes to the Senate.

S/UR System Monitors Medicaid Expenditures

Marjorie G. Kelley, Ph.D.* Ohio Department of Public Welfare

IN BOTH HUMAN and financial terms, Medicaid is the largest program administered by the Ohio State Department of Public Welfare (ODPW). Over \$300,-000,000 is paid annually to Ohio medical practitioners and institutions, almost exclusively in the private sector of the health-care-delivery system. Nearly 700,000 indigent Ohioans of all ages are eligible for medical care under this program.

Jointly financed by State and Federal governments, the total cost of Ohio's Medicaid program includes about 54 percent in Federal matching funds for the current fiscal year. Participating physicians must be eligible by professional status and must complete applications and

compliance agreements with ODPW.

Since this is a large expenditure of public monies (yours and mine!), State government would be remiss if such disbursements were not carefully monitored. In fact, Federal laws and regulations mandate that Medicaid operations be analyzed and evaluated by a Surveillance and Utilization Review (S/UR) unit. The overall objective of the S/UR system is to improve the State agency's capability to administer its Medicaid program efficiently and effectively.

Welfare Department personnel are aware of the value of physicians' cooperative participation in the Medicaid program and appreciate difficulties facing them in filling out a large volume of forms, using correct codes, and coping with "red tape." Yet the need for monitoring is clear, and understanding the process may foster productive collaboration. As a retrospective or post-payment procedure, S/UR has two major concerns: medical and administrative.

Medical and Administrative Concerns

Monitoring and assuring the quality and level of medical care delivered to Medicaid recipients is a principal focus of S/UR. This system establishes statistical profiles of health-care-delivery and utilization patterns in order to safeguard and improve the caliber of service provided. Among basic issues are: lengths of hospital stay, diagnostic laboratory screening, medical procedures, and prescribing of drugs.

Administrative concerns of S/UR involve proper and legal utilization of Medicaid by physicians and recipients. In the monitoring process, millions of claims, hundreds of thousands of recipients, and tens of thousands of providers are reviewed in order to isolate cases of exceptional utilization. Individual profiles thus developed are evaluated against norms of peer groups. When significant deviations from norms are detected, they are reported as exceptions and require investigation.

Handling such enormous amounts of data obviously demands an elaborate computerized system. Reports are routinely generated showing summaries of groups, indi-

viduals (providers and recipients), treatment analyses, and claim details. Management summaries give averages, standard deviations, and upper and lower limits for various categories of service, diagnoses, and age groups. Innumerable special reports can be produced when needed in an investigation.

Among the areas of exceptional utilization frequently shown by indicators in S/UR's reporting system are:

excessive or insufficient visits to patients in hospitals, nursing homes, or offices

 unusual prescribing practices as shown by ratio of drug prescriptions to visits and recipients, by percent addictive drugs prescribed, or by other contraindicated use of medications

• frequent delayed surgery

- inordinate diagnostic procedures indicated by ratios of laboratory tests to recipients and visits, number of different physician procedures, and similar indicators
- excessive injections or referrals to specialists

• under-utilization of long-term-care facilities

Other questions are raised by use of incorrect codes for diagnoses, treatments, procedures, etc.

Corrective Action

Where abuse is established, corrective measures are accomplished through education, administrative action (e.g. termination as eligible providers), peer review or professional society sanctions, legal action through courts or licensing bodies, and reclamation of monies wrongfully collected.

To perform this monitoring function, S/UR staff has received intensive training in skills necessary to review, analyze, interpret, evaluate, and apply data to the S/UR process. Also available for consultation on medical questions are several medical doctors, allied specialists, and other medically trained staff.

In summary, S/UR is necessary to assure that Medicaid recipients receive medical care comparable to that available to the general population. It is also responsible for exercising fiscal control over State and Federal tax dollars, for assuring compliance with Federal and State laws and regulations, and for guarding against fraud and abuse of the Medicaid program by individual physicians and recipients. It recognizes a responsibility to help physicians comply with the rules for maximum benefit to all involved.

Marjorie Kelley is Supervisor of the Bureau of Surveillance & Utilization Review. This unit is in the Division of Medical Assistance, directly under the Director of the Ohio Department of Public Welfare. Submitted by the O.D.P.W., the article does not necessarily reflect the views of OSMA.

Ohio Health News

John H. Ackerman, M.D., M.P.H.

Director of Health

Ohio Public Health Trust Makes First Annual Distribution of Funds

The Ohio Public Health Trust has approved the distribution of \$349,006 to pediatric care centers in six

Ohio hospitals.

The Ohio Public Health Trust was created in 1974 to handle disbursement of funds awarded to the state of Ohio as the result of a class action suit against five major pharmaceutical manufacturers alleging they had conspired since 1953 to increase the price of broad spectrum antibiotic tetracycline and its derivatives.

Under conditions of the Trust, the principal and income may be used for establishing and maintaining pediatric pulmonary care centers in designated Ohio

In this first annual disbursement of funds, awards were made to the following hospitals in the amounts

Columbus Children's Hospital	\$82,407
Akron Children's Hospital	44,551
Cincinnati Children's Hospital	28,000
Dayton Children's Medical Center	60,325
Cleveland's Rainbow Babies and	
Children's Hospital	84,448
Medical College of Ohio at Toledo	48.875

Trustees of the Ohio Public Health Trust are The Director of Health; Gertrude Donahey, Treasurer of Ohio; and Martin Essex, State Superintendent of Edu-

Montgomery County Education Program for Paramedic

The Montgomery County Education Program for the Paramedic will be funded for another year. This award will provide \$80,000 to finance the existing program for a 12-month period ending June 30, 1976. Montgomery County had received \$79,000 during the preceding 12 months. Under conditions of the grant Good Samaritan Hospital will provide 240 hours of training for 300 ambulance technicians to raise them to the level of paramedics. The training program will include experience in hospital emergency rooms, intensive care units, coronary care units, and cardiac monitoring units.

Mercer County Gets Emergency Medical Services Award

An emergency medical services grant of \$17,575 has been approved for Mercer County for the purchase of a new ambulance and communications equipment. The new vehicle will give the commissioners a total of six ambulances with which to begin a county-wide ambulance service operated by the Celina Fire Department. In addition to ambulances located at the Celina fire station,





DESCRIPTION: Methyltestosterone is 178-Hydroxy-17-Methylandrost-4-en-3-one. ACTIONS: Methyltestosterone is an oil soluble androgenic hormone. INDICATIONS: In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. PRECAUTIONS: Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avold stimulation to the point of increasing the nervous, mental, and physical activities promised cardiac reserve or renal disease. In treating males for symptoms of climacteria, avold stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. CONTRAINDICATIONS: Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. WARNINGS: If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. ADVERSE REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. DOSAGE AND ADMINISTRATION: Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg; Postpuberal cryptorchism, 30 mg. HOW SUPPLIED: 5, 10, 25 mg. In bottles of 60, 250.

Write for Literature and Samples

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2500 West Sixth Street, Los Angeles, California 90057

ambulance substations manned by volunteers will be established in Rockford and St. Henry.

Ohioans Attend Alcoholism Institute

Forty-one persons sponsored by the Ohio Department of Health successfully completed the 1975 Midwest Institute of Alcohol Studies held this year in Madison, Wisconsin the first week in June. The Institute is an educational project designed to provide basic information on alcohol problems for professional people whose work brings them in contact with these problems.

Coshocton County to Have-County-Wide Emergency Ambulance and Invalid Coach Service

Coshocton County commissioners have been notified that their application for an emergency medical services grant of \$69,000 has been approved. This award will enable the county to purchase four new ambulances with two-way radios and a base radio station. The commissioners are in the process of instituting a comprehensive ambulance and invalid coach service which will consist of the two new vehicles and two ambulances presently operated by the Warsaw emergency squad. Under the new plan, the six ambulances will be operated by the Coshocton County Emergency Squad Association and will be based

at two locations in Coshocton and at stations in Keene and West Lafayette. The sheriff's department will be the dispatch center for all ambulance calls.

Hypertension Classes Available to Local Health Departments

The divisions of Chronic Diseases and Nutrition have conducted the first in a series of classes on hypertension that will be available to local health departments on request. This first in a series of four two-hour classes was held recently at the Troy City-Miami County Health Department.

Middleburg Gets Grant for Ambulance Supplies

A grant of \$2,925 has been awarded to the city of Middleburg for the purpose of purchasing ambulance supplies and two-way radios for a new emergency medical service. Middleburg Heights Fire Department presently operates two ambulances and rescue vehicles. This grant will provide improved emergency medical service not only at the scene of an accident, but also enroute to the hospital. The city also has mutual aid agreements for ambulance service with Berea, Brookpark, Strongsville, Parma Heights and North Royalton.

Anabolic Stimulant Increased Muscular Tone Osteoporosis

EACH ANDROID-G TABLET CONTAINS:

Ethinyl Estradiol	. 0.005 mg
Methyltestosterone	
L-lysine	
Nicotinic Acid	
Iron (from Ferrous Sulfate)	
Vitamin A	
Vitamin D	J.S.P. Units
Thiamine Mononitrate	
Riboflavin	
Ascorbic Acid	
Folic Acid	
Vitamin B-12	
Methionine	
Choline Bitartrate	
Inositol	
Calcium Pantothenate	
Pyridoxine	
Copper (from Copper Sulfate)	0.25 ma
Zinc (from Zinc Oxide)	0.25 ma
lodine (from Potassium lodide	. 0.075 ma
Calcium (from Dicalcium Phosphate	72.5 mg
Phosphorus (from Dicalcium Phosphate)	55 ma
Potassium (from Potassium Sulfate)	
Manganese (from Manganese Sulfate)	
Magnesium (from Magnesium Sulfate)	0.5 mg

ACTION AND USES — DOSAGE: 1 tablet after breakfast and supper, or as required. In females, 3-week courses of therapy are recommended followed by a 1-week rest period. Withdrawal bleeding may occur during the rest period. Withdrawal bleeding may occur during the rest period. PRECAUTIONS: Administer cautiously to female patients who tend to develop excessive hair growth or other signs of masculinization. CONTRAINDICATIONS: Patients in whom estrogen or androgen therapy should not be used, as in carcinoma of the breast, genital tract, or prostate, and in patients with a familial tendency to these types of malignancy. AVAILABLE: Bottles of 100 and 500 tablets. Rxonly.

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A Community Hospital Revamps Its Continuing Education

Ralph E. Pickett, M.D.

THERE IS ALMOST universal agreement that the half life of a medical education is about five years and that continuing education is now a lifetime requirement. Most surveys indicate that continuing educational programs must be prescribed on an individual basis. Each physician must choose the method which is most effective for him or her.

There is a difference of opinion as to whether it should be voluntary or compulsory but the trend is toward requiring at least a minimal number of hours for staff appointments and relicensure. Regardless of the method chosen, it is very important to remember that the basic objective is to improve patient care. This is accomplished in four stages.

Four Stages For Improving Patient Care

The first stage involves medical care evaluation or peer review in order to find out what needs to be changed. The second stage is continuing education in learning how to make the necessary changes by correcting outdated knowledge, introducing new knowledge, and mastering new skills and techniques.

The third stage, that of making the actual change, is the crucial one, requiring motivation and energy. Without it the first two stages are a waste of time. Finally, it is necessary in the fourth stage to evaluate regularly to see if actual change has been accomplished. This can be done by returning to both concurrent and retrospective peer review. We thus have an ongoing circular process with internal feedback. It is a dynamic and continuing process.

Continuing Medical Education Was Haphazard Before 1967

Licking Memorial Hospital, located in Newark, Ohio, is a 350 bed general hospital. It is the only hospital in a county of 108,000 people. There is an active medical staff of 75 plus an associate staff and a consulting staff. Prior to 1967, continuing medical education was carried out in a haphazard fashion. It was directed by a staff appointed educational chairman and an education committee.

Scheduling of educational conferences depended upon the availability of suitable movies, speakers from other hospitals, and unusual cases. The pathologist was the only full-time hospital based physician. Visiting professors spoke on a subject which they were researching at the time. The subject was usually not related to our own cases.

Beginning in 1962, we were associated with the Ohio Medical Education Network and had two way radio conferences with surrounding medical schools. We subscribed to PAS and MAP but the findings were not put to practical use and only a few of the medical staff knew how to interpret and use the data. Clinical Pathological Conferences and patient teaching rounds were scheduled only when an interesting case was available.

The students in our hospital based School of Radiologic Technology and our School of Medical Technology attended Denison University for specific courses. We had no other affiliation with an educational institution at that time

The staff had many committees to study tissues, transfusions, etc. Most physicians served on five or six such committees. At irregular committee meetings, the task was to read through a pile of charts reviewing them on a personal basis. There was little or no communication with other members of the same committee and none with other related committees. Therefore, no actual audit was made.

Revamping Educational Routines

In 1966 we moved into a new, modern hospital. Since we added many new techniques and installed new sophisticated equipment, we had to send many of our physicians, nurses and other employees to other hospitals to develop new skills. A full-time hospital based Director of Cardiology was employed and Coronary and Intensive Care Departments were instituted. The Board of Trustees employed a physician to serve as full-time Director of Education and Development.

We decided to revamp our educational routines and introduce continuing education in all hospital departments. We became affiliated with the College of Medicine at Ohio State University and the School of Nursing at Capital University. At the request of OSU, we joined the pilot program on computer assisted instruction.

Our hospital became involved with four Regional Medical projects such as the study of strokes and training of coronary care nurses. We combined a number of our staff committees and decided to educate to our weak-



Two of the major committees appointed were Utilization and Medical Care Evaluation. Since each reports to the Executive Committee, this began a Quality Assurance Program. The same physicians on the Medical Care Evaluation Committee are also on the Education Committee. These two committees meet the same day so that our educational program can be tied into our medical audit. The Medical Record Librarian and the Director of Nurses are also on the Medical Care Evaluation Committee, and the In-Service Nurse Director and the Director of the School of Nursing are part of the Education Committee.

The nine physicians represent all of the hospital services including Pathology and X-ray. The individual members are assigned, on a rotating basis each month, to review either deaths, autopsies, infections, transfusions, tissues or bad results. Their individual work assignment may extend over a week or more and they often work with other staff members in preparing their reports.

In addition, the various services are assigned in rotation to prepare a retrospective review on a subject outlined by the committee or chosen by the service. A copy of this report is given to the Utilization Committee as part of its monthly review. Joint Medical and Nursing audits are prepared four times each year.

Educational conferences are held each Monday and Friday at noon, with the hospital providing an excellent buffet lunch. The conferences vary, including patient rounds, case studies, clinical pathological conferences, visiting lecturers and Med-Com film programs. National Medical Education television programs are shown on Tuesday, Wednesday, Thursday and Saturday providing an educational program six days a week! A scientific portion of each monthly staff meeting is also part of the overall program.

The teaching staff consists of those physicians on our staff dedicated to the development of planned educational activities. We try to get as many involved in each program as possible. Frequently, teachers are enlisted from other hospitals and medical schools but all programs are centered around our own patients. Medical students who are working in our hospital with preceptors are sometimes assigned programs. We have discovered that a moderator is essential to all programs in order to develop interesting debate and widespread discussion.

Interesting pathology slides, unusual cardiology cases with their cardiographic findings, and unusual x-rays are on display in the hospital library. Each month an educa-

tional paper is printed containing recent medical and drug information.

We are now affiliated with Ohio State University College of Medicine; OSU-Newark (Psychology and Paramedic Training); Central Ohio Technical College (Nursing and Radiologic Technology); Ohio Northern University Pharmacy School (5th year students); Denison University (pre-med students); Columbus Technical Institute (Medical Technology); Ohio State University and Northwestern University (Residents in Administration). Nineteen members of our staff are on the teaching faculty of the School of Medicine and many are involved with students and visiting residents.

Organized training exists in all hospital services and we cooperate with and encourage all community health training such as cancer, drugs, alcohol, arthritis, expectant parents and emergency medical training. More and more attention is being paid to patient education.

Eight Guidelines For Success

Some programs have been tried and discarded and new projects are constantly being tested. The most recent change is the addition of a self-study room. It appears certain that an educational environment keeps everyone on their toes and contributes to better patient care. During the past eight years we have found that successful, continuing medical education programs for practicing physicians in a community hospital must:

- Be convenient
- Have regular and constant scheduling
- Be relevant and patient oriented
- Be designed to obtain specific objectives
- · Be varied
- Require active participation by the audience
- Be checked by evaluation studies
- Have careful and accurate attendance records for certification, staff reappointment and probable relicensure.

Dr. Pickett is Director of Medical Affairs and Director of Education at Licking Memorial Hospital, Newark. He also serves as a Clinical Assistant Professor of Surgery at The Ohio State University College of Medicine. He is a past president of OSMA's Section on Directors of Medical Education.



THE OHIO STATE MEDICAL JOURNAL IS A BICENTENNIAL PARTICIPANT.

King George III's Insanity Porphyria: A Royal Malady

Frank Batley, Esquire, M.B., Ch. B.

MOST ADMIT that the attitude of George III helped to unite the rebels in the years leading to 1776. It has long grieved me that we have not given credit to this monarch for his help in persuading the diffident and some of the Tories to join the rebels; the latter today might be called left-wing—or perhaps communists. All George III did was to propose a few miniscule taxes. It is reliably reported that each year on April 15, his tomb at Windsor Castle rocks as if he were shaking with laughter.

The British later made a scapegoat of George III. They tended to blame the errors of his ministers on his attacks of insanity—but was he really insane?

Investigating George III's Mental Illness

In the 1960's a psychiatrist, Doctor Ida Macalpine, began to look into George III's mental history. In various Royal Museums there are boxes of notes written by some of George III's servants and diaries written by his physicians. Apparently, when a king dies there is a scramble to clear his quarters in order to make way for the new monarch. Therefore, letters and much junk were crated, stored, and forgotten until some historian wished to sift through them.

Eventually, Doctor Macalpine made some extraordinary findings. She came across several references to the unusual color of the king's urine after it had been kept overnight in his chamber-pot. The urine was described as darkish brown and sometimes purple. Such purple urine is typical of Porphyria. The disease waxes and wanes; but, during attacks, the concentration of this abnormal metabolite produces severe effects. In addition to colic and diarrhea, some mental disturbance is common. The sufferer is quite normal between acute attacks.

The story is contained in a booklet which was published in 1968 by the *British Medical Journal*. The front

piece is a picture of George III. The color of the binding is purple, and, on the back, is a beautiful crest showing a crown over a combination of half a tudor rose and half a thistle. Some of you may now realize the identity of the real culprit, but for now I will leave you to guess who this was.

Until Doctor Macalpine's research, George's illnesses had been regarded as a manic depressive psychosis. Psychiatrists as recently as 1955 had written about typical aspects of his personality. For instance, they remarked about his timidness in sexual activities. Yet, George III had fifteen children, which seems to suggest that he overcame his shyness on at least fifteen occasions. The idea of his sexual inhibitions arose because there is no record of his having had any mistresses. From this arose the classic quotation "you are damned if you don't and damned if you do."

The King's Physician

Why did George's physicians not make the correct diagnosis? Well, first of all, Porphyria had not been discovered; and it is difficult to make a diagnosis of a condition that is unknown. Also, we should remember that medical knowledge was primitive. Clinical thermometers had not yet been invented, nor had the stethoscope.

The following is an extract from a medical bulletin about his condition and is a model of how to say nothing:

"His majesty has had a restless night and is this morning much indisposed. He is under a great degree of irritation and the whole frame is so much disturbed as to make us consider Him in some danger."

Lord Grenville complained "the report of the physicians is worded as foolishly as ever." One may wonder why they did not describe the king's urine. However, it seems that a century or so before, fashionable physicians made extensive studies of patients' urine, smelling and tasting.

In a previous century when James I was sick, his physician reported "the King rose very early and with great vigor went stag hunting until two in the morning. Upon his return he had retention of urine but later passed

Dr. Batley is Director of the Division of Radiation Therapy at Ohio State University Hospitals. He is also a Professor of Radiology in the School of Medicine. A native of Oldham, England, Dr. Batley received much of his education in that country.

blood-red urine, turbid with a thick red sediment." One can hardly but be amazed that after twenty hours of continuous hunting, King James would not have had some upset; all that time in the saddle! At least we can be sure he did not have hemorrhoids.

This era of infatuation with urine, like other fashions in medicine, passed into disrepute. As Doctor Macalpine says: "physicians of the era prior to the eighteenth century were known as 'piss-prophets.'"

Mary, Queen of Scots Passes the Gene

Doctor Macalpine began to inspect records about the ancestors of George III written by these piss-prophets. The answer came quickly. The crest I have mentioned of a crown over half a tudor rose and half a thistle is the Regal Crest of Mary, Queen of Scots. Porphyria is considered hereditary, and the dominant gene had descended from her through the Royal Family.

Mary was reported as having attacks of colic, diarrhea and bloody urine from puberty. With these attacks were bouts of hysteria. When she was 28, it was reported that:

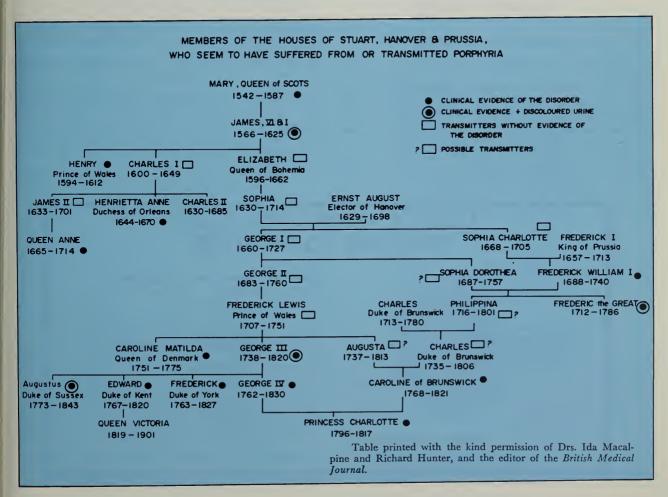
"she was much molested with a continewall destillation from her head into her stomack,

whereof hath growen such debilitie and weaknes in that part, that she nether hath desire to anie meate, neyther facultie to reteyne that long . . . she vomits with a greit inflamation and tension in her left side, under the short ribbes which retchith so farr every waie, that they yet doubt whether it be the inflamation of the stomack, the splene, the wombe, or all of those thre partes together."

Another physician reported her condition as "obstructio splenis cum flatu hypochondrica." Queen Mary's son, James I, had similar attacks; and his physicians described his urine as sometimes blood red and sometimes like Alicante wine.

In all, Doctor Macalpine noted that fifteen members of the British royal family are thought to have had this disease, including Mary, Queen of Scots, her son James I, his great-granddaughter, Queen Anne, and later George III, George IV and George IV's brother, the Duke of Kent. This Duke of Kent was the father of Queen Victoria.

The descendants of George III had much opportunity to spread their seed around Europe so that Doctor Macalpine and her team were able to trace many other cases. There are two living descendants known to have



Porphyria; but Doctor Macalpine does not say who they are, merely calling them patients A and B.

Many of the royal children died at an early age; and some died so suddenly with convulsions, that there were rumours of foul play by poisoning. Perhaps some of these suffered from Porphyria. Indeed, George III's granddaughter, Princess Charlotte, who is now believed to have had the disease, died in childbirth while being delivered of a stillborn son. This prince, had he lived, would have succeeded to the throne. The succession was then in confusion until Princess Charlotte's rather aged uncle, the Duke of Kent, was persuaded by a generous financial allowance from Parliament to forsake his mistress and marry. From this union was born the princess who later became Queen Victoria.

I have mentioned that it is thought that Queen Anne also suffered from the disease, and it is worth mentioning that she was pregnant seventeen times. However, only one son lived beyond infancy; and he died at the age of 12. It was the lack of surviving offspring from Queen Anne that brought the Hanoverians to the throne. Although they were somewhat distant in the line of succession, they still carried the defective gene. So, from George I to George II and then George III. It was George III in whom the disease was most virulent although there were long periods of remission.

Declared Insane After Ruling 51 Years

George's first attack of mental illness was in 1765 when he was six years old. Eventually, his attacks of insanity became public knowledge; and his physicians had the embarrasing task of being questioned by the Privy Council as to whether or not he was insane. The Privy Council has nothing to do with privies as we understand them today, though in this context, had there been a council in the privy, we might have been closer to the truth. The council had the same difficulties as we have in this country to decide when a president is incapable of

conducting his duties and should be replaced by the vice president.

The king's physicians were divided into two camps. The Prince of Wales, who would rule as Prince Regent, favored the group of politicians who wanted the king declared insane. This led to what was called the Regency Crisis. Each time the Regency Bill came close to passage, the king recovered. You may remember that he had his first attack in 1765 when he was six, yet he lived to be 82 years old, and the Regency Act which deposed him was passed only in 1812, when he was 73!

The Prince of Wales, who had waited so long for his father to be declared insane, eventually became Prince Regent with the power of the monarch.

In summary, George III became king in 1760 when he was 22 years old and died in 1820 when he was 82. During his long reign he had recurrent attacks of insanity from Porphyria. Perhaps in this bicentennial year, one might suggest that it would be a suitable and appropriate gesture to change the color of the red stripes in the flag of the United States to purple, thus, acknowledging the contribution that George III made in founding this great republic!

Much of this article is derived from papers by Dr. Ida Macalpine and her associates published in the British Medical Journal in 1966 and 1968. I have added some scurrilous inferences of my own such as the indication that George III or his Porphyria should be given more respect as a predominant feature in the founding of this republic.

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- 1. Macalpine, Ida, and Hunter, Richard: The "Insanity" of King George III: A Classic Case of Porphyria. British Medical Journal, 8: January, 1966.
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 3. Brooke, John: Historical Implications. British Medical
- Journal, 13: January, 1968.

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obituaries_

Prominent Columbus Physician, Dies at Age 69

Any national or international history of medicine is certain to contain the names of the distinguished Harding family of Columbus and Worthington. One of them is Warren Gamaliel Harding II, M.D., who was named for his uncle, President Warren G. Harding. Dr. Harding died at his home on June 28. The second son of Dr. George T. Harding, who founded Harding Hospital in Worthington, Dr. Harding has three children, two of whom are physicians and a third who is a dentist; his widow, Francis Keller Harding, M.D., is also a well known Columbus physician. Also surviving are two physician brothers, both of Worthington, a sister in Texas, a physician sister in California, and eight grandchildren.

Dr. Harding's illustrious career started after obtaining his medical degree from Loma Linda University School of Medicine in 1930 where he was first in his class and wrote the highest grade in the National Board Examination

He had been decorated by the Republic of China following W.W. II for his medical contribution to that country. Dr. Harding has served as director of medical education, president of the medical staff, chief of surgery and finally as administrator of Grant Hospital from which he retired in 1972. He acquired a Ph.D. degree in education from Ohio State University in 1966 and commenced a book on the medical history of American Presidents. He was a trustee and former vice president of the Ohio Historical Society, member of the Knights Templar, the American College of Surgeons, Phi Delta Kappa and Sigma Chi Fraternities, Past President of Ohio State Surgical Society, Past President of the Sons of the American Revolution. Past President of the academy of medicine of Columbus and Franklin County, member of the Ohio State Medical Association and the American and British Medical Associations and numerous organizations.

Joseph Montgomery Black, M.D., Cleveland; Western Reserve University School of Medicine, 1942; age 60; died June 11; member of OSMA and AMA.

Peter A. Bruch, M.D., Cleveland; Western Reserve University School of Medicine, 1952; age 53; died June 12; member of OSMA and AMA.

Thomas Stone Gerspacher, M.D., Miami, Florida; University of Louisville School of Medicine, 1933; age 69; died May 13; former member of OSMA and AMA.

Henry Harrison Gibson, M.D., Akron; University of Louisville School of Medicine, 1928; age 76; died June 11; member of OSMA and AMA.

Faith Wilson Reed, M.D., Cleveland; University of Pittsburgh Medical School, 1924; age 77; died June 5; member of OSMA and AMA.

Fred Fogel Shepard, M.D., College Corner; New York Medical College, 1931; age 71; died June 2; former member of OSMA.

Robert G. Slusher, M.D., Columbia Falls, Montana; University of Cincinnati College of Medicine, 1932; age 70; died June 1; member of OSMA and AMA.

Paul Norman Squire, M.D., San Diego, California; Western Reserve University School of Medicine, 1925; age 76; died June 21; former member of OSMA and AMA.



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NEW MEMBERS

Following are names of new members of the Ohio State Medical Association certified to the headquarters office during June, 1975. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

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CONTINUING

回 IN OHIO

Ohio Regional Meeting of the American College of Physicians—Mohican State Park Lodge, Mansfield; September 26-27; Contact: Wm. H. Bunn, Jr., M.D., F.A.C.P., P.O. Box 240, Youngstown, Ohio 44501.

AMA Congress On Occupational Health; September 29-30; Cincinnati; contact: AMA's Dept. of Environment, Public and Occupational Health, 535 N. Dearborn St., Chicago, Ill. 60610: registration fee is \$30.

Neurological Syndromes Associated with Cancer: Robert Reed, M.D.; Current Concepts in Tumor Immunotherapy: Albert Lobuglio, M.D.; Current Concepts in the Treatment of Breast Caner: John Minton, M.D.; State of the Art in Cancer Chemotherapy: Richard L. Meyer, M.D., Oct. 2; Sponsored by the Tumor Registry Committee of the Medical and Dental Staff of the Good Samaritan Hospital, Cincinnati, 45220.

Pediatrics for the Practicing Physician—Commodore Perry Motor Inn, Toledo; October 3-5; sponsored by the Medical College of Ohio, Toledo Pediatric Society, Ohio Chapter of American Academy of Pediatrics; contact: Howard S. Madigan, M.D., Assoc. Dean for Continuing Education, Medical College of Ohio, P.O. Box 6190, Toledo, Ohio 43614.

Emergency Care, Part II—Shawnee State Park Lodge, Portsmouth; October 10, 11, 12; sponsored by the Scioto County Medical Society and Portsmouth Academy of Family Practice.

Family Practice Refresher; October 20-24; sponsored by Ohio Academy of Family Physicians; Holiday Inn, 328 W. Lane Ave., Columbus; contact: OAFP, 4075 North High St., Columbus, 43214; \$250 for physicians; \$150 for family practice residents; acceptable for 40 prescribed postgraduate credit hours by American Academy of Family Practice.

Case Western Reserve University For further information: School of Medicine 2109 Adelbert Road Cleveland 44106

Ear, Nose & Throat and the Practicing Physician; October 29.

What's New In Pediatrics: Sam Spector Day; November 12; Case Western Reserve University, Pediatric Clinical Faculty, Fifth Annual Symposium. Subjects: Current and future developments in medical care of children; immunology, neonatology, hematology, and respiratory disease. Faculty: Samuel Spector, M.D., Samuel Gross, M.D., Avroy Fanaroff, M.D., Carl Doershuk, M.D., Stephen Polmar, M.D., Marshall Klaus, M.D., no fee. Contact: S. S. Strassman, M.D., Pediatric Dept., Rainbow Babies and Childrens Hospital, University Circle, Cleveland. 44106.

The Critically Injured Patient: Emergency Surgical and Medical Care; November 13, 14, & 15; the Marriott Inn, Cleveland, O. Sponsored by the American College of Surgeons Committee on Trauma and the Department of Surgery, Case Western Reserve Medical School, Cleveland. Fee is \$150 for physicians and \$50 for interns and residents. Contact: the ACS Trauma Division, 55 Erie St., Chicago, Illinois 60611, or Dr. Mark A. Mandel, University Hospitals of Cleveland, 2065 Adelbert Rd., Cleveland, Ohio 44105. Approved for 20 hours of AMA Category 1 credit and 20 hours accreditation of the American Academy of Family Practice.

Ninth Annual Urology X-Ray Seminar; December 7-9; Stouffer's Cincinnati Inn; Contact: Arthur T. Evans, M.D., Div. of Urology, University of Cincinnati Medical Center, 231 Bethesda Ave., Cincinnati, 45267.

(continued on next page)



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Conference on Biofeedback—Fort Wayne campus of Indiana University-Purdue University; September 4 and 5; fee is \$80; for additional information write or phone, Indiana University-Purdue University, Department of Continuing Education, 2101 Coliseum Blvd., East, Fort Wayne, Indiana 46805, phone (219) 482-5526.

National Conference on Cancer Research and Clinical Investigation—replacing the Eighth National Cancer Conference; September 20-22; Regency Hyatt Hotel, Atlanta, Ga.; Contact: Sidney L. Arje, M.D., American Cancer Society, Inc., 219 E. 42nd St., New York, New York 10017.

The 1975 John I. Perlstein Memorial Lecture-Treatment of Acute Lymphocytic Leukemia in Children; September 22; Health Science Center Auditorium, University of Louisville; Contact: Department of Pediatrics, Children's Hospital, Health Sciences Center, P.O. Box 1055, Louisville, Kentucky 40202.

Scientific Foundations for Clinical Practice; September 26-28; Sponsored by the Office of Continuing Education of the Colleges of Medicine and Nursing, University of Kentucky; Contact: Frank R. Lemon, M.D., Office of Continuing Education, College of Medicine, University of Kentucky, Lexington, Ky. 40506. Telephone (606) 233-5161.

Dermatology Symposium; October 1-3; New York University Post-Graduate Medical School; Tuition is \$250; for residents in training, \$125. Further details are available from the office of the Associate Dean, New York University Post-Graduate Medical School, 550 First Ave., New York, N.Y., 10016; telephone (212) 679-3200, ext. 4037.

Neurosurgery 1975; October 1-4; New York University Post-Graduate Medical School; Tuition is \$250; for residents in training, \$150. Contact: Office of the Associate Dean, New York University Post-Graduate Medical School, 550 First Ave., New York, N.Y. 10016; or telephone (212) 679-3200, extension 4037.

Purdue Defibrillation Conference-Lafayette, Indiana; October 1-3; fee is \$95; contact: Division of Conferences and Continuation Services, Stewart Center, Purdue University, West Lafayette, Indiana 47907.

Johns Hopkins Medical Institutions For further information: Administrator, Office of Continuing Education Johns Hopkins Medical Institutions Turner Auditorium, Room 17 720 Rutland Avenue Baltimore, Maryland 21205-Phone (301) 955-5880

Seminars in Laboratory Medicine; Sept. 1, 1975-June 30, 1976; Johns Hopkins Hospital; Approved for 34 hours of AMA Category 1 credit.

Psychodrama—Theory and Technique; September 8, 1975-January 22, 1976; Phipps Clinic; Approved for 24 hours of AMA Category 1 credit.

Diagnostic Ultrasound in Obstetrics and Gynecology; September 11-December 12; Turner Auditorium; Approved for 14 hours of AMA Category 1 credit.

Sleep Disorders; September 13; Sheraton-Baltimore Inn; approved for 8 hours of AMA Category 1 credit.

Emil Novak Course in Gynecological, Pathology, Cytogenetics & Endocrinology; September 22-26; Turner Auditorium; approved for 40 hours of AMA Category 1 credit.

Diagnosis and Treatment of Sexual Disorders: II; September 25-28; Hunt Valley Inn; approved for 25 hours of AMA Category 1 credit.

Topics in Gastroenterology and Liver Disease; October 2-4; Turner Auditorium; approved for 16 hours of AMA Category 1

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- William M. Wells, Newark Dwight L. Becker, Lima Oscar W. Clarke, Gallipolis Richard L. Meiling, Columbus
- PUBLIC RELATIONS
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 Robert E. Zipf, Dayton
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STATE ASSOCIATION OFFICERS AND COMMITTEEMEN (Continued)

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MEDICAL CARE
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Gregory G. Floridis, Dayton
Wesley L. Furste, Columbus
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Robert C. Waltz, Cleveland

EMPLOYEES' PENSION COMMITTEL James L. Henry, Grove City, *Chairman* William R. Schultz, Wooster Mr. Hart F. Page, Columbus

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Rex H. Wilson, Akron, Chairman
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James J. LaPolla, Warren
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Victor A. Simiele, Lancaster
Howard S. Van Ordstrand, Cleveland
Robert A. Vogel, New Lebanon
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Jerry L. Hammon, West Milton
B. Leslie Huffman, Jr., Maumee
Jack Schreiber, Canfield
William R. Schultz, Wooster
Robert G. Thomas, Elyria

County Society Roster— Officers and Meeting Dates

UPDATED THROUGH MAY I, 1975

First District

- Councilor: Stephen P. Hogg, Cincinnati 45219 250 Wm. Howard Taft Rd.
- ADAMS—Kenneth C. Jee, M.D., President, West St., Winchester 45697; Nora Ancheta, M.D., Secretary, 39 Vine St., Peebles 45660; Tuesday of Jan., April, July, and Oct.
- BROWN—Charles Hannah, M.D., President, Sardinia Medical Clinic, Sardinia 45171; Robert S. Benintendi, Secretary-Treasurer, R.R. #1, Box N, S. Main St., Georgetown 45121; Third Sunday.
- BUTLER—James R. Carr, M.D., President, 42 N. Seventh St., Hamilton 45011; E. Clifford Roberts, Executive Secretary, 111 Buckeye St., Hamilton 45011; Fourth Wednesday of each month.
- CLERMONT—Babulal K. Shah, M.D., President, 146 North 3rd St., Williamsburg 45176; William B. Selnick, D.O., Secretary-Treasurer, Second & E. Loveland Ave., Loveland 45140; Third Wednesday of each month.
- CLINTON—Thomas M. Faehnle, M.D., President, 88 N. Howard St., Sabina 45169; Foster J. Boyd, M.D., Secretary, 644 W. Main St., Wilmington 45177.
- HAMILTON—Edmund C. Casey, M.D., President, 437 Melish Ave., Cincinnati 45219; William Galligan, Executive Director, 320 Broadway, Cincinnati 45202.
- HIGHLAND—Glenn B. Doan, M.D., President, 528 South St., Greenfield 45123; Walter Felson, M.D., Secretary-Treasurer, 357 South St., Greenfield 45123.
- WARREN—Orville L. Layman, M.D., President, 22 W. 4th, Franklin 45005; Second Tuesday of month.

Second District

- Councilor: W. J. Lewis, Dayton 45419 2567 Far Hills Ave.
- CHAMPAIGN—Victor R. Frederick, M.D., President, 848 Scioto St., Urbana 43078; John H. Flora, M.D., Secretary-Treasurer, 848 Scioto St., Urbana 43078; Second or third Wednesday.
- CLARK—Hans G. Bredemeyer, M.D., President, 1054
 E. High St., Springfield 45505; Mrs. Fonda Geer,
 Executive Secretary, 616 N. Limestone St., Rm. 131,
 Springfield 45503; Third Monday.

- DARKE—Leroy M. Steinbrecher, M.D., President, 1117 S. Towne Ct., Greenville 45331; Peter H. Mulder, M.D., Secretary, Arcanum Medical Center, 602 N. Main St., Arcanum 45304; Third Tuesday.
- GREENE—Edward P. Call, M.D., President, 1142 N. Monroe Dr., Xenia 45385; Mrs. V. Jones, Executive Secretary, 1003 Parnell Dr., Xenia 45385.
- MIAMI—Walter Meeker, M.D., President, 550 Summit Ave., Troy 45373; Richard H. Burk, M.D., Secretary, 550 Summit Ave., Troy 45373; First Tuesday.
- MONTGOMERY—Albert A. Brust, M.D., President, 2600 Far Hills Ave., Dayton 45419; Earl E. Shelton, Executive Director, 280 Fidelity Medical Bldg., Dayton 45402.
- PREBLE—John D. Darrow, M.D., President, 1302 North Aukerman St., Eaton 45320; Joseph R. Williams, M.D., Secretary-Treasurer, 401 North Barron St., Eaton 45320.
- SHELBY—George J. Schroer, M.D., President, 20 S. Main St., Fort Loramie 45845; William F. Mentges, M.D., Secretary, 870 S. Main Ave., Sidney 45365; Second Tuesday of March, June, Sept. and Nov.

Third District

- Councilor: John C. Smithson, Findlay 45840 521 W. Sandusky St.
- ALLEN—Fred D. Rohdes, M.D., President, 825 W. Market, Lima 45805; Mr. Waldo Smith, Executive Secretary, Box 803, Lima 45801; Third Tuesday of month, Sept. through May.
- AUGLAIZE—Barbara Cummins, M.D., President, 310 Perry St., Wapakoneta 45895; Joseph Larj, M.D., Secretary-Treasurer, 5 S. Blackhoof, Wapakoneta 45895; First Tuesday every second month.
- CRAWFORD—Thomas K. Huggins, M.D., President 955 Bucyrus Rd., Galion 44833; Douglas Angerman, M.D., Secretary, 270 Portland Way South, Galion 44833.
- HANCOCK—C. L. Samuelson, M.D., President, 539 S. Main St., Findlay 45840; H. A. Mahler, M.D., Secretary, 117 E. Wallace St., Findlay 45840.
- HARDIN—Glen B. Van Atta, M.D., 900 E. Franklin St., Kenton 43326; Robert A. Thomas, M.D., Secretary-Treasurer, Mt. Victory 43340; Second Tuesday.

- LOGAN—David Miller, M.D., President, 1006 N. Main St., Bellefontaine 43311; Suk W. Lee, M.D., Secretary-Treasurer, 1400 S. Main, Bellefontaine 43311.
- MARION—Antonio Mortera, M.D., President, 1051 Harding Mem. Pkwy., Marion 43302; David G. Paff, M.D., Secretary-Treasurer, 399 E. Church St., Marion 43302.
- MERCER—John W. Chrispin, M.D., President, 209 N. Main, Rockford 45882; Richard L. Dobbins, M.D., Secretary-Treasurer, 131 E. Fayette, Celina 45822; Third Thursday.
- SENECA—Mohammad Anvari, M.D., President, 1316 W. Ridge Dr., Fostoria 44830; Rosario Bello, M.D., Secretary-Treasurer, 1230 Roosevelt Dr., Fostoria 44830; Third Tuesday.
- VAN WERT—Wilmer Iler, M.D., President, Medical Arts Bldg., Fox Rd., Van Wert 45891; Donald Hughes, M.D., Secretary-Treasurer, Van Wert County Hospital, Van Wert 45891.
- WYANDOT—Herschel A. Rhodes, M.D., President, 777 N. Sandusky Ave., Upper Sandusky 43351; F. M. Smith, M.D., Secretary, Box 165, Sycamore Associates, Sycamore 44882; Second Tuesday at 11:30 a.m.

Fourth District

Councilor: C. Douglass Ford, Toledo 43607 2361 W. Bancroft St.

- DEFIANCE—John Mitchell, M.D., President, 1400 E. Second St., Defiance 43512; Subash Mathew, M.D., Secretary-Treasurer, 1400 E. Second St., Defiance 43512.
- FULTON—R. Lee Davis, M.D., President, 137 S. Fulton St., Wauseon 43567; Gerald A. Perkins, D.O., Secretary-Treasurer, Rt. #1, Box 20-A, Delta 43515; First Tuesday.
- HENRY—Thomas F. Moriarty, M.D., President, 651 Strong St., Napoleon 43545; K. E. Dye, D.O., Secretary-Treasurer, Box 5, Liberty Center 43532; First Tuesday.
- LUCAS—John A. Devany, M.D., President, 2105 Shenandoah Rd., Toledo 43607; Lee F. Wealton, Executive Director, 3101 Collingwood Blvd., Toledo 43610; Fourth Tuesday.
- OTTAWA—James Rhiel, M.D., President, P.O. Box 579, Port Clinton 43452; Guillermo V. Crisologo, M.D., Secretary-Treasurer, 602 E. 6th St., Port Clinton 43452.
- PAULDING—Doyt E. Farling, M.D., President, 301 S. Main St., Payne 45880; Don K. Snyder, M.D., Secretary-Treasurer, Rt. #2, Payne 45879; Third Monday.

- PUTNAM—Charles Kidd, M.D., President, Kalida 45853; Oliver N. Lugibihl, M.D., Secretary, Box 235, Pandora 45877.
- SANDUSKY—John C. Bates, M.D., President, 1937 Glen Spring Dr., Fremont 43420; Mrs. Patsy J. Askins, Executive Secretary, Memorial Hospital of Sandusky County, Fremont 43420; Quarterly.
- WILLIAMS—Richard L. Hess, M.D., President, Bryan Medical Group, Bryan 43506; Virgil N. Carrico, M.D., Secretary-Treasurer, Bryan Medical Group, Bryan 43506.
- WOOD—Charles Smith, M.D., President, 351 E. Boundary St., Perrysburg 43551; F. Frederick Householder, Secretary-Treasurer, 735 Haskins Rd., Bowling Green 43402; Third Thursday.

Fifth District

Councilor: John J. Gaughan, Cleveland 44102 7911 Detroit Ave.

- ASHTABULA—Morris Wasylenki, M.D., President, 430 West 25th St., Ashtabula 44004; Amy Housel, Executive Secretary, P.O. Box 1772, Ashtabula 44004; Second Tuesday.
- CUYAHOGA—Frederick T. Suppes, M.D., President, 2154 Noble Rd., Cleveland 44112; Robert A. Lang, Executive Director, 10525 Carnegie Ave., Cleveland 44106.
- GEAUGA—Oscar Oca, M.D., President, 13346 Ravenna Rd., Chardon 44024; Mrs. Martha Withrow, Executive Secretary, Geauga Community Hospital, P.O. Box 249, Chardon 44024; Second Thursday except July and Aug.
- LAKE—Robert D. Hochstetler, M.D., President, 36001 Euclid Ave., Willoughby 44094; Mrs. Marge Mclaren, Executive Secretary, 7408 Cadle Ave., Mentor 44060; Jan. 22, March 19, May 28, Sept. 17, Nov. 19, 1975 (Fourth Wednesday evening unless otherwise ordered by the Council.)

Sixth District

- Councilor: C. Edward Pichette, Youngstown 44512 1019 Boardman-Canfield Rd.
- COLUMBIANA—John Madison, M.D., President, 2020 State St., Salem 44460; Mrs. Gilson Koenreich, Executive Secretary, 193 Park Ave., Salem 44460; Third Tuesday.
- MAHONING—Rashid Abdu, M.D., President, 2111 Belmont Ave., Youngstown 44505; Howard Rempes, Jr., Executive Secretary, 245 Bel-Park Bldg., 1005 Belmont Ave., Youngstown 44504; Third Tuesday, Jan., March, May, Sept., Nov., Dec.

- STARK—Henry H. Clapper, M.D., President, 1445 Harrison Ave., N.W., Canton 44708; John H. Austin, Executive Secretary, 405 4th St. N.W., Canton 44702; Second Thursday.
- TRUMBULL—Jerome J. Stanislaw, M.D., President, 1814 Coventry N.E., Warren 44483; Mrs. Kay Ticknor, Executive Secretary, P.O. Box 1328, Warren 44482; Third Wednesday, Sept. through May.

Seventh District

- Councilor: Robert E. Rinderknecht, Dover 44622 404 N. Walnut St.
- BELMONT—Theron R. Rolston, M.D., President, 4211 Noble St., Bellaire 43906; Nermin D. Lavapies, M.D., Secretary, 342 Jefferson, Tiltonsville 43963; Third Thursday except Jan., July and August.
- CARROLL—Robert Hines, M.D., President, Minerva Clinic, 625 N. Market St., Minerva 44657; Samuel Weir, M.D., Secretary-Treasurer, Minerva Clinic, 625 N. Market St., Minerva 44657; Third Tuesday.
- COSHOCTON—Myeong S. Lee, M.D., President, 775 S. 2nd St., Coshocton 43812; Myron Saturski, M.D., Secretary-Treasurer, 149 S. Bridge St., Newcomerstown 43832; Second Tuesday.
- HARRISON—Janis Trupovnieks, M.D., President, Box 338, Hopedale 43976; Ajit Modi, M.D., Treasurer, Rd. #1, Cadiz 43907.
- JEFFERSON—Paul Ruksha, M.D., President, 633 Lawsen Ave., Steubenville 43952; Mrs. Bess Simpson, Executive Secretary, P.O. Box 655, Steubenville 43952; First Tuesday.
- MONROE—Byron Gillespie, M.D., Secretary-Treasurer, 158 S. Main, Woodsfield 43793.
- TUSCARAWAS—Dale R. Kollman, M.D., President, Box 341, Tuscarawas 44682; Keith C. Van Epps, M.D., Secretary, 404 N. Walnut St., Dover 44622.

Eighth District

- Councilor: Richard E. Hartle, Lancaster 43130 414 E. Main St.
- ATHENS—James R. Gaskell, M.D., President, 400 E. State St., Athens 45701; L. A. Hamilton, M.D., Secretary, 400 E. State St., Athens 45701; Second Tuesday, March, June, Sept., and Dec.
- FAIRFIELD—James Merk, M.D., President, 1582 E. Main St., Lancaster 43130; David H. Sheidler, M.D., Secretary-Treasurer, 1500 E. Main St., Lancaster 43130; Second Tuesday.

- GUERNSEY—Clarence Apel, M.D., President, 130 S. Tenth St., Cambridge 43725; Zosimo Maximo, M.D., Secretary-Treasurer, 1330 N. Clark St., Cambridge 43725.
- LICKING—Alfred J. Eckhardt, M.D., President, 66 McMillen Dr., Newark 43055; Dorothy Watson, Executive Secretary, Licking County Memorial Hospital, Newark 43055; Fourth Tuesday except June, July and Aug.
- MORGAN—A. H. Whitacre, M.D., President, Chester-hill 43728; Henry Bachman, M.D., Secretary, 426 E. Union Ave., McConnelsville 43756.
- MUSKINGUM—Gordon E. Gifford, M.D., President, 760 Linden, Zanesville 43701; Hudnall J. Lewis, M.D., Secretary-Treasurer, 515 Taylor, Zanesville 43701; First Tuesday.
- NOBLE—Frederick M. Cox, M.D., President, P.O. Box 330, Caldwell 43724; Edward G. Ditch, M.D., Secretary-Treasurer, Box 239, Caldwell 43724; First Tuesday.
- PERRY—Charles E. Bope, M.D., President, W. Main St., Clouse Clinic, Somerset 43783; Michael P. Clouse, M.D., Secretary, W. Main St., Somerset 43783.
- WASHINGTON—L. Eugene Plummer, Jr., M.D., President, 215 Marion St., Marietta 45750; Fortunato R. Macatol, M.D., Secretary-Treasurer, 102 Wyandotte Dr., Marietta 45750; Second Wednesday except June, July, Aug. and Sept.

Ninth District

- Councilor: Thomas W. Morgan, Gallipolis 45631 Holzer Medical Center, Box 344
- GALLIA—Richard B. Simpson, M.D., President, P.O. Box 709, Gallipolis 45631; Donald M. Thaler, M.D., Secretary-Treasurer, Holzer Medical Center Clinic, Gallipolis 45631.
- HOCKING—Owen F. Yaw, M.D., President, 461 E. Second St., Logan 43138; John W. Doering, M.D., Secretary-Treasurer, 42 N. Spring St., Logan 43138.
- JACKSON John Zimmerly, M.D., President, 35 Vaughn St., Jackson 45640; Carl Greever, M.D., Secretary-Treasurer, 35 Vaughn St., Jackson 45640.
- LAWRENCE—David A. Pack, M.D., President, 505 Mulberry St., Ironton 45638; George N. Spears, M.D., Secretary-Treasurer, 422 South Sixth St., Ironton 45638; Quarterly.

- MEIGS—Roger P. Daniels, M.D., President, 206½ East Main St., Pomeroy 45769; Joseph J. Davis, M.D., Secretary-Treasurer, 939 Ash St., Middleport 45760.
- PIKE—William W. Wiltberger, M.D., President, 330 E.North St., Waverly 45690; Joseph Benutto, M.D.,Secretary, 411 Emmitt Dr., Waverly 45690.
- SCIOTO—Richard Villarreal, M.D., President, Center Plaza Medical Center, 613 Center St., Wheelersburg 45694; Lowell Thompson, Executive Secretary, P.O. Box 1348, Portsmouth 45662; Second Tuesday.
- VINTON-No active society.

Tenth District

- Councilor: J. Hutchison Williams, Columbus 43214 4355 Sharon Avenue
- DELAWARE—George J. Parker, M.D., President, 43 Northwood Dr., Delaware 43015; Don R. Thomas, D.O., Vice President, 377 E. William St., Delaware 43015; Lloyd E. Moore, M.D., Secretary-Treasurer, Magnetic Springs 43036; Third Tuesday except June, July, Aug.
- FAYETTE—Robert A. Heiny, M.D., President, Box 457, Washington C.H. 43160; Marvin Roszmann, M.D., Secretary-Treasurer, 1005 E. Temple St., Washington C.H., 43160; Second Monday.
- FRANKLIN—J. Hutchinson Williams, M.D., President, 4355 Sharon Ave., Columbus 43214; James S. Imboden, Executive Secretary, 600 S. High St., Columbus 43215; Feb. 18, 1975; April 17, 1975; Golf outing in Sept.; Oct. 21, 1975; Dec. 5, 1975; Christmas party.
- KNOX—Robert Westerheide, M.D., President, 307
 Vernedale Dr., Mt. Vernon 43050; Alan Fairchild, M.D., Secretary, 5 N. Gay St., Mt. Vernon 43050; First Wednesday.
- MADISON—John Sullivan, D.O., President, 10086 Columbus-Cincinnati Rd., South Charleston 45368; Theodore Froncek, D.O., Secretary-Treasurer, 58 E. Main St., West Jefferson 43162; Four meetings a year.
- MORROW—Joseph P. Ingmire, M.D., President, 28 W. High St., Mt. Gilead 43338; Francis Kubbs, M.D., Secretary-Treasurer, 140 N. Main St., Mt. Gilead 43338; First Tuesday.
- PICKAWAY—Robert McCoy, M.D., President, 125 N. Pickaway, Circleville 43113; Francis W. Anderson, M.D., Secretary-Treasurer, 630 Northridge Rd., Circleville 43113; Second Tuesday.
- ROSS—William J. Corzine, Jr., M.D., President, 217 Delano Ave., Chillicothe 45601; Roy E. Manning, M.D., Secretary-Treasurer, 612 Central Center, Chillicothe 45601; First Thursday.

UNION—John B. Ziegler, M.D., President, Rt. #4, Marysville 43040; May B. Zaugg, M.D., Secretary-Treasurer, Rt. #5, 18008 Timber Lane, Marysville 43040; First Tuesday, Feb., Apr., Oct., Dec.

Eleventh District

- Councilor: Robert G. Thomas, Elyria 44035 630 East River St.
- ASHLAND—Vera Chalfant, M.D., President, 309 Arthur St., Ashland 44805; Charles A. Slagle, D.O., Secretary-Treasurer, 350 Hillcrest Ave., Ashland 44805; First Thursday.
- ERIE—Arthur Groscost, M.D., President, 1218 Cleveland Rd., Sandusky 44870; Mrs. David Wolfert, Executive Secretary, Scheid Rd., Box 381E, Huron 44839; Second Tuesday except July and Aug.
- HOLMES—William Powell, M.D., President, 9 W. Adams St., Millersburg 44654; Paul Roth, M.D., Secretary-Treasurer, N. Main St., Killbuck 44637.
- HURON—John V. Emery, M.D., President, 218 Myrtle
 Ave., Willard 44890; Shan A. Mohammed M.D.,
 3 Milan Dr., Milan 44846; Second Wednesday,
 Feb., Apr., June, Oct. and Dec.
- LORAIN—William F. Nichols, M.D., President, 621 East River St., Elyria 44035; Mrs. Gladys Davidson, Executive Secretary, 1480 N. Ridge Rd., E., Elyria 44035; Second Tuesday except June, July, Aug.
- MEDINA—Liborio M. Marty, M.D., President, P.O. Box 133, Medina 44256; John E. Gerding, Executive Secretary, 3377 Forest Hills Dr., Medina 44256; Third Thursday.
- RICHLAND—Donald E. Mills, M.D., President, 480 Glessner Ave., Mansfield 44903; Mrs. M. K. Leggett, Executive Secretary, Mansfield General Hospital, Mansfield 44903; Third Thursday.
- WAYNE—Jerry N. Bosnak, M.D., President, 1740 Cleveland Rd., Wooster 44691; Walter H. Kearney, M.D., Secretary-Treasurer, 1740 Cleveland Rd., Wooster 44691; Second Wednesday.

Twelfth District

- Councilor: William Dorner, Jr., Akron 44303 750 W. Market St.
- PORTAGE—Donald Hammel, M.D., President, 449 S. Meridan St., Ravenna 44266; Alif A. Kuri, M.D., Secretary-Treasurer, 250 S. Chestnut St., Ravenna 44266; Second Tuesday.
- SUMMIT—Charles A. East, M.D., President, 292 E. Exchange St., Akron 44304; S. H. Mountcastle, Executive Director, 430 Grant St., Akron 44311; First Tuesday, Jan., March, May, Sept., and Nov.

It isn't often that I miss attending a National Auxiliary convention but miss it I did this year and of course, it was my loss. And of course I had to have an on-thescenes "stand in" to report the important annual meeting for this column. I was lucky, for no less a person than the versatile Mrs. Robert E. Krone, our new state president, agreed to come to my rescue. She is no novice at writing columns as newspaper readers in Cincinnati can testify. Here is her first-hand account:

"A national convention is many things—pageantry, fellowship, education, and business. It is exhiliarating and exhausting. It reaches heights and drops to depths. It is something to experience, to remember and to share. When the AMA House of Delegates convened at Howard Johnson's Motor Lodge in Atlantic City for its fifty-third annual meeting on June 16, your Ohio delegation was there in full strength. We had met the evening before to discuss the issues on the agenda. We also had enjoyed the traditional Ohio Breakfast Monday morning just before the opening session.

"The keynote speaker, Dr. Malcolm Todd, 1974-75 president of the American Medical Association, stated: 'Auxiliary has so many things going for it that it is difficult to know where to begin. Your greatest triumph is the \$1,361,564.21 this year for AMA-ERF. We are proud of what you are doing!' Dr. Todd then tackled the biggest problem of the AMA—the professional liability crisis. He indicated that we all have a tremendous responsibility to conduct an educational campaign. We must obtain public support through auxiliary and physician action. Dr. John Budd (from Cleveland), vice-president of AMA-ERF, thanked the auxiliary for its incredible work. 'Your continuing record-breaking contributions have earned you the gratitude of medical schools across the country,' said Dr. Budd. He recognized the efforts of national and regional chairmen.

"In her summary of the 1974-75 auxiliary year, Mrs. Howard Liljestrand, 1974-75 national president, emphasized accomplishments, problems and alternatives for the future. 'I still have a dream, but now it's a different dream, for the one I had a year ago has been fulfilled by you,' she told the delegates. 'I marvel at what you have accomplished. Officers and chairmen come and go but the mainstream keeps right on moving.' She listed the advantages of recent joint planning between the auxiliary and the medical association. She discussed the proposed increase in national dues. Mrs. Liljestrand indicated that increased funds will provide more materials to more persons, increased mailings, an opportunity to improve membership billing and collection procedures and to replace reserve funds. The alternative, she pointed out, is to allow ourselves to be slowly starved by inflation.

"Succeeding business sessions included state reports and recognition of achievement. Ohio received an award

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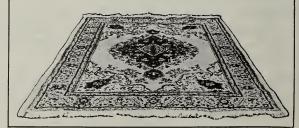
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for its contribution of \$15.49 per capita to AMA-ERF (Ohio's total contribution was \$76.519.78). We are also proud recipients of a certificate of achievement for our efforts in the area of health education, Mrs. S. I. Glueck. 1974-75 Ohio president, featured Erie County's project in her report before the National House of Delegates.

"Featured speaker on Tuesday morning was Mary Louise Smith, national chairman of the Republican Party. who reviewed the various bills that have passed Congress. resulting in the expenditure of billions annually for health education and services in this country. Mrs. Smith urged her audience to become involved in politics. 'No one has more reason to be involved in politics,' she said, 'than doctors, except perhaps their wives.'

"After much discussion, the House of Delegates finally agreed to increase membership dues to the national organization an additional three dollars. This will make national dues a total of seven dollars annually, beginning with the 1976-77 auxiliary year. Several amendments to the By-laws were passed. The most significant are: 1) changing the name to the American Medical Association Auxiliary; 2) defining the purposes as exclusively educational and charitable: 3) simplifying the various membership categories; 4) deleting the office of second vicepresident and four of the directors; 5) adding the appointment of a coordinator to implement the Project Bank.

"In the closing session on Wednesday, Mrs. Erle E. Wilkinson was installed as the 1975-76 president by a former national president from her home state of Tennessee. Mrs. Rogers N. Herbert was the thirteenth president of the AMA auxiliary forty years ago. Mrs. Wilkinson

in her inaugural address said that we need to get it all together. 'There is a new year ahead-we have come through one of change. Crises face our husbands, our neighbors and ourselves. Straighten out your life, organize your work and get it all together.' Mrs. Wilkinson suggested that we avoid the extremes of sticking to the old or swaving with every crisis. 'We need to be knowledgeable about legislation,' she emphasized. 'We need to tell the health story as it really is continue to raise funds for medicine and improve the quality of life. We need to focus our thinking on the needs of our communities and use the Project Bank for specific programs to meet those needs. The Project Bank is a means of sharing ideas. It is our communication system. Remember, information is giving out; but communication is getting through."

The "New" Fall Workshop

It's a regional format this year for Fall Workshop east, west and central. The idea is to bring the workshop closer to the counties. The first will be held on September 9 in Delaware (central) for districts 9, 10 and 11. The second will be on September 16 in New Philadelphia (east) for districts 5, 6, 7 and 8. The third will be on September 23 in Wapakoneta (west) for districts 1, 2, 3 and 4. The State Board meeting and luncheon will be on September 8 in Delaware. Mrs. William A. Myers, state president-elect and Fall Workshop chairman, has this to say: "The recipe for Auxiliary Happiness is easy and it's fun-Blend fellowship with fulfilling projectsand serve to everyone!"

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In This Issue:

Allied Medical Inc564
Boehringer Ingelheim Ltd557-562
The Brown Pharmaceutical Co., Inc574-575
Burroughs Wellcome Co
Daniels-Head582
Dorsey Laboratories, Div. of Sandoz-Wander, Inc551
Flint Laboratories, Div. of Travenol Lab., Inc
Harding Hospital597
Lilly, Eli and Company540
The Medical Protective Company586
Menendian, K. A. Carpets596
The Park Plaza Hotel538
Pharmaceutical Manufacturers Association

Roche Laboratories, Div. of Hoffman- La Roche, Inc Inside Front Cover-537, Inside Back Cover, and Back Cover
Roerig & Co., Div. of Pfizer569
Schmidt's Sausage Haus587
Searle Laboratories, Div. of G. D. Searle & Co
SK&F Co., Subsidiary of Smith, Kline & French Laboratories568
Spangler Candy Co581
Sperry Remington Office Systems583
Turner & Shepard, Inc580
Unica Distributors588
University Center596
The Upjohn Company552-553
Wendt-Bristol Co
Windsor Hospital598



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VOL. 71

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NO. 11



Original and Scientific Articles

EVALUATION OF THE USE OF COMPUTER-ASSIST ELECTROCARDIOGRAPHIC READINGS IN A 700-BED GENERAL HOSPITAL 619 Don C. Nouse, M.D., Toledo

BURN THERAPY PROGRAM IN A COMMUNITY HOSPITAL 622 Robert K. Finley, Jr., M.D., and Vicki Little, R.N., Davton

IMMUNOSUPPRESSIVE THERAPY IN RHEUMATIC DISFASES. A RETROSPECTIVE STUDY 624 Marvin H. Thomas, M.D.; Waldemar Bergen, M.D.; Vol K. Philips, M.D.; and Norman O. Rothermich, M.D.; Columbus

MATERNAL HEALTH IN OHIO: MATERNAL DEATHS FOLLOWING UNATTENDED DELIVERY 627 By the OSMA Committee on Maternal Health

Special Articles

NEW HELP FOR THE DISABLED PHYSICIAN 641

A GIANT STEP FOR OHIO MEDICINE 650 Ohio's new malpractice law alleviates the malpractice crisis and promotes the highest quality of medical care through medical, legal and insurance reforms.

SHAPING A MEDICAL MALPRACTICE BILL 654

INDIAN REMEDIES 661 R. Gordon Moore

Features

608 Woman's Auxiliary 673 News Continuing Education 636 617 Comments **Obituaries** 672 633 Ohio Health News Journal Advertisers 676 Council Minutes 610 Classified Ads 675 671 New Members

Medical Board Adopts Position On Hypnosis

The law regarding hypnosis for medical purposes has been interpreted as follows by the Ohio State Medical Board:

- 1) Hypnosis for medical purposes (i.e., either examination or therapy) can only be used by licensed physicians; i.e., Doctors of Osteopathy and Doctors of Medicine or by licensees of other Regulatory Boards who by legislative action are entitled to such practice.
- 2) The use of hypnosis for medical purposes by unlicensed individuals, irrespective of whether the patients are referred by a licensed physician, constitutes the illegal practice of medicine and is therefore in violation of Section 4731.34.

Judges To Choose 1976 Miss Wheelchair America

"There is nothing wrong, sad or different about being disabled," says Diana Kenderian, Miss Wheelchair America 1975. "The problems arise when society shuts the disabled out."

The Miss Wheelchair America Pageant was started three years ago to promote public awareness of the disabled. The judging to select Miss Wheelchair America 1976 will be September 28 in the Neil House Hotel, Columbus. The public is invited to attend.

"The average able-bodied person is unaware of the barriers that society places upon disabled women," said Ernest W. Johnson, M.D., Chairman of the Department of Physical Medicine and Rehabilitation, The Ohio State University, and president of the pageant. "We want to stimulate public interest so that architectural barriers and attitudinal discrimination against the disabled will be eliminated."

The first pageant, held in 1972, attracted contestants from three states. Forty states will be represented in this year's pageant, as well as a representative from Puerto Rico.

Judging for the contest is based on three areas: 40 percent on achievement after the accident or illness; 30 percent on poise and ability; and 30 percent on appearance. The contestant may be either married or single. She must spend at least one-half of the day confined to a wheelchair.

The winner receives a \$3,000 scholarship to the college of her choice. She appears on television and speaks before numerous organizations around the nation, as a spokeswoman for the more than 500,000 Americans confined to wheelchairs.

Unfortunately, Dr. Johnson is concerned that this year's pageant may be the last due to a lack of financial support. "It takes about \$20,000 to sponsor the pageant, house the contestants and their companion aides for three days, and provide meals and transportation," he said. "We are contacting Ohio businesses and foundations, as well as accepting donations from individuals. Still, we are running short."

\$670,000 Appropriated For Osteopathic School

The legislature passed a bill establishing a school of osteopathy at Ohio University in Athens. Both OSMA and the Ohio Board of Regents opposed Am. H.B. 229 (Fries, D-Dayton) because it usurps funds needed for family practice residency programs.

Clinical instruction for the new school will be provided through facilities of existing osteopathic and joint staff hospitals. The bill contains an appropriation of \$670,000 to begin the school. Osteopathic physicians in Ohio have pledged \$1,000,000 as an assessment over the next six years.

The total amount appropriated by the current General Assembly for family practice programs in Ohio's six medical schools is \$1,470,000.

Cleveland Clinic Exhibit Wins Hektoen Silver Medal

A scientific exhibit prepared by Alan H. Wilde, M.D. and other members of the Department of Orthopaedic Surgery of The Cleveland Clinic Foundation won the Hektoen Silver Medal for Original Investigation at the AMA Annual Convention. The exhibit is entitled "Geometric II Knee Replacement Arthroplasty."

Collaborating with Dr. Wilde in preparing the exhibit were H. Royer Collins, M.D.; John A. Bergfeld, M.D.; and Alan S. Greenwald, M.D.

The Geometric II knee replacement prosthesis is an improved version of the original geometric prosthesis. Several modifications have been made to improve fixation and avoid complications. New instrumentation has also been provided which simplifies the insertion of the prosthesis.

Is Your Ohio License Valid?

It has been brought to OSMA's attention that some of our members have not renewed their Ohio licenses. Notices for license renewals were mailed to physicians by the Ohio State Medical Board in November, 1974. If you did not receive a notice, it could be because the Medical Board does not have your current address. In this case, we suggest that you contact the Ohio State Medical Board, 180 E. Broad Street, Columbus 43215. It is important that you have a valid license.

Ohio Doctors Recognized For Nuclear Medicine Work

Two Ohio physicians have received the highest honor the American College of Nuclear Medicine confers. Antonio Rodriguez Antunez, M.D. of Cleveland and D. Bruce Sodee, M.D. of Mayfield Heights were conferred the Degree of Fellowship of the American College of Nuclear Medicine at its annual meeting in Florida.

Medical Specialists To Be Listed In Yellow Pages

Responding to demands from physicians and the public, Ohio Bell has announced plans to begin listing doctors under their specialized medical fields in the Yellow Pages.

According to the telephone company, recent nationwide survey results have shown that more than 35 million adults use the Yellow Pages to find doctors and other medical services. These adults average 7.8 uses per person for a total of more than 270 million references a year.

Initially, the new Yellow Pages classified headings will be offered only in large metropolitan areas served by Ohio Bell. The Dayton telephone directory, scheduled for delivery in next February, will be the first book to have the new headings. Other cities where the medical speciality listings will be offered are Youngstown, Cleveland, Springfield, Massillon, Canton, Middletown, Columbus, Painesville, Toledo and Akron.

The 53 medical speciality listings recognized by the American Medical Association are to be offered in addition to regular Yellow Pages listings under "Physicians

and Surgeons." Cost will be minimal.

Representatives of Ohio Bell's Yellow Pages will be contacting physicians about establishing new listings approximately six months before the directories are distributed in each city.

Since more than 20 percent of the nation's population moves each year, patients coming into new communities should have an easier time locating a specialist after the medical specialty headings are established in the phone books. And the new system also will help persons searching for specialized medical treatment in an emergency.

OSMA Golfers Announce 1975 Tournament Winners

Ralph R. Ballenger, M.D., of Columbus, fired a three under par 69 to win overall low net honors in the Ohio State Medical Golfers Association's 1975 tournament at Akron's Portage Country Club.

Playing to a two handicap, Dr. Ballenger led the entire field of 92 physician linksmen.

Kenneth E. Owens, M.D., of Marietta, posted a 77-12-65 for low net honors.

Low gross and low net winners by age groups were: To age 39: low gross — Carlos E. Pena, M.D., Lorain, 84; low net — John A. Walker, M.D., Portsmouth, 87-16-71.

Age 40 to 49: low gross — David M. Bell, M.D., Lakewood, 75; low net — William M. Emery, M.D., Ashland, 80-10-70.

Age 50 to 59: low gross — E. R. Zartman, M.D., Columbus, 74; low net — P. O. Staker, M.D., Mansfield, 77-11-66.

Age 60-69: low gross — Maurice F. Lieber, M.D., Canton (President of the Ohio State Medical Association) 78; low net — Delbert A. Russell, M.D., Elyria, 80-12-68.

Age 70 and older: 70-year-old George M. Wilcoxen, M.D., Alliance, and 80-year-old F. T. Gallagher, M.D., Rocky River, tied for low gross with a pair of 94's. Dr. Wilcoxen plays to a 10 handicap, Dr. Gallagher to a 12 handicap.

J. R. Morehead, M.D., Columbiana, age 75, won low net in the 70 and older age group with his 94-18-76.

The Ohio State Medical Golfers Association was organized in 1921.

proceedings of the council

A regular meeting of the Council of the Ohio State Medical Association was held Saturday and Sunday, July 12-13, 1975, at the OSMA Headquarters' office, 600 South High Street, Columbus, Ohio.

Those present Saturday were: All members of the Council (with the exception of Drs. Stephen P. Hogg and Thomas W. Morgan); James E. Pohlman, Esq., Columbus, OSMA Legal Counsel; P. John Robechek, M.D., Cleveland, Chairman, Ohio Delegation to the American Medical Association; John H. Budd, M.D., Cleveland, Member of the AMA Board of Trustees; and Messrs. Page, Edgar, Gillen, Campbell, Clinger, Rader, Houser, Mulgrew, Holcomb, Freeman, Mrs. Wisse and Ms. Doll, of the OSMA.

Those present Sunday were: All members of the Council (with the exception of Drs. Stephen P. Hogg and Thomas W. Morgan); Mr. Pohlman, Dr. Robechek, Dr. Budd, and Messrs. Page, Edgar, Gillen, Campbell, Clinger, Houser, Holcomb, Freeman and Mrs. Wisse, of the OSMA Staff.

The meeting was called to order by President Lieber. The minutes of the April 26-27, May 15 and June 3 meetings of the Council were approved.

By official action, the Council Meeting was convened in a closed session.

Subsequently, the regular session was reconvened, and the President named the following Task Force to coordinate the defense of an Antitrust Suit filed in Federal Court in Columbus by the Ohio Attorney General against Ohio Medical Indemnity, Inc., and the Ohio State Medical Association: James C. McLarnan, M.D., Mt. Vernon, Chairman; Oscar W. Clarke, M.D., Gallipolis; George N. Bates, M.D., Toledo; Robert G. Thomas, M.D., Elyria; Maurice F. Lieber, M.D., Canton, Ex Officio; Hart F. Page, Staff. The Task Force is to work with James E. Pohlman, Legal Counsel.

Membership

Membership statistics were presented by Mrs. Wisse.

Fiscal Matters

The minutes of the Committee on Auditing and Appropriations meeting, July 11, 1975, were presented in a closed session and were approved, as a whole, as amended.

American Medical Association

A report on the Annual Meeting of the American Medical Association, June 15-19, in Atlantic City, was presented by Dr. Robechek and Dr. Budd.

OSMA Annual Meeting

The Council took up the matter of referring 1975 House of Delegates resolutions to the appropriate committees for implementation, as follows:

Am. Res. 1-75, Professional Liability — referred to the Task Force on Professional Liability.

Am. Sub. Res. 2-75, Professional Liability Commission - referred to the Task Force on Professional Liability.

Am. Res. 5-75, Norms or Criteria of Medical Care - referred to the Committee on Government Medical Care Programs and to Medical Advances Institute.

Am. Res. 6-75, HEW Regulations in Regard to Utilization Review Under the Social Security Act resolution forwarded to the AMA where it was adopted; referred to the Committee on Government Medical Care Programs.

Sub. Res. 7-75, Employ Non-Staff Physicians to do PSRO, Utilization Review, Certification and Review referred to the Committee on Government Medical Care Programs and to the OSMA Government Medical Care Programs Newsletter

Res. 8-75, PSRO Information and Confidentiality (A) — referred to the Committee on Government Medical Care Programs and to the OSMA Government Medical Care Programs Newsletter.

Sub. Res. 9-75, PSRO Information and Confidentiality - referred to the Committee on Government Medical Care Programs and to the OSMA Government Medical Care Programs Newsletter.

Am. Res. 17-75, Peer Review Programs — referred to the Department of Federal Legislation, Medical Advances Institute and the Committee on Government Medical Care Programs.

Am. Res. 21-75, Clarification of Res. 23-74 — Information received by the Council; referred to the Ohio Delegation to the American Medical Association.

Am. Res. 18-75, Confidentiality - referred to the Ohio Delegation to the AMA and was adopted by AMA in June.

Sub. Res. 22-75, Third Party Carriers - referred to Committee on Insurance.

Am. Res. 23-75, AMA Fiscal Responsibility—referred to the AMA Delegation; adopted by the AMA in

Am. Sub. Res. 24-75, Continuing Medical Education - referred to the Commission on Medical Education.

Res. 25-75, Catholic Hospital Association — referred to the Committee on Hospital Relations, to the Catholic Hospital Association and to the AMA Delegation; adopted by the AMA in June.

Res. 26-75, Abortion Advertising — referred to the Committee on Judicial and Professional Relations.

Am. Res. 27-75, Special Committee to Analyze Published Health Statistics for Dissemination to the Physicians — referred to the Committee on Private Practice.

Res. 28-75, Development of Outreach Program for Heart Disease and Stroke - referred to the Committee on Public Relations and the Department of Health Education.

(continued on page 613)

proceedings of the council

Res. 30-75, Early Detection of Breast Cancer referred to the Committee on Cancer.

Am. Sub. Res. 29-75. Legislation to Protect Supply of Life Saving Drug - referred to the Committee on Pharmacy Relations; committee has filed statement with the FDA. National Pharmaceutical Council and the American Pharmaceutical Manufacturers Association. and has released a statement to the media

Am. Sub. Res. 31-75, Information-Medical Advances Institute - referred to Medical Advances Institute and to county medical societies.

Sub. Res. 32-75. Surveys — referred to the Committee on Public Relations.

Res. 36-75, Semi-annual Meeting of OSMA House of Delegates - referred to the Committee on Auditing and Appropriations.

Sub. Res. 37-25, Nomination of District Councilors - referred to Special Committee on Constitution and

Bylaws.

Am. Sub. Res. 40-75, Creating a Twelfth Councilor District - William Dorner, Jr., M.D., Akron appointed as Twelfth District Councilor 5/14/75; confirmed by the Council 5/15/75; redistricting matters referred to the Committee on Membership and Planning.

Res. 43-75, Student Membership — to 1975 Bylaws

revision.

Res. 44-75, Fiscal Notes — to 1975 Bylaws revision. Res. 45-75, Report on Professionalism — Resolution 10-74 repealed.

Res. 46-75, Publication of Budget — to 1975 Bylaws

revision.

Res. 47-75, Affiliate Members — to 1975 Bylaws revision.

Res. 48-75, Hearing of Resolutions Involving Ethics — to 1975 Bylaws revision.

Sub. Am. Res. 50-75, H.B. 682 — referred to Task Force on Professional Liability.

Medical Advances Institute

The Council studied proposed Articles of Incorporation and Bylaws for the Ohio Health Data Corporation. Full consideration was deferred until the next meeting of the Council.

Ohio Medical Indemnity, Inc.

A report on the May 28, 1975 Executive Committee meeting was presented by Dr. Henry.

Ohio Foundation for Medical Care

Minutes of the Board of Directors meetings of June 4 and July 2, 1975, were presented by Mr. Gillen.

Committee Reports

Thomas E. Rardin Family Practice Scholarships Committee

The minutes of the Thomas E. Rardin Family Practice Scholarships Committee meeting of June 18, 1975 were presented by Mr. Clinger and were accepted. Commission on Medical Education

The minutes of the Commission on Medical Education meeting of June 25, 1975, were presented by Mr. Edgar, who announced the accreditation of the Newark Hospital and the Chillicothe Veterans Hospital. The minutes were accepted.

Committee on Membership and Planning

The minutes of the Committee on Membership and Planning meeting of July 2, 1975, were presented by Mr. Gillen, and were accepted.

Council Fee Review Committee

A report on the Council Fee Review Committee meeting of July 11, 1975, was presented by Mr. Campbell, and was amended and accepted.

Other Meetings

Mr. Page reported on the June 11 meeting of the officers of the Ohio State Bar Association and the Ohio State Medical Association.

Mr. Page and Mr. Clinger reported on a meeting, June 23, with Governor Rhodes with regard to the bond issue for inner city cancer centers and heart center. Council directed the Committee on Cancer to study a proposal submitted to the Ohio Department of Health for a 200-bed cancer hospital in Columbus.

(continued on page 666)

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comments

Lord, That I Might See

Most of us never have to beg for the gift of sight. It is given freely, used indiscriminately, often mistreated, seldom appreciated. Perhaps, if we were forced to beg for our vision, we might be more concerned for its safety and care and more interested in preventing anything which might damage our eyes.

Yet, the eyes of over 2.000 Ohioans are statistically scheduled to become blinded during the coming year. Whether that blindness is due to accident or disease, if the knowledge we now have is continually applied, the vision of more than one-half of these could be saved. Furthermore, hundreds more could be saved from vary-

ing degrees of vision impairment.

That is why we, the Ohio Society for the Prevention of Blindness, Inc., have launched our annual September Sight-Saving Campaign for the purpose of public education and fund raising. Through voluntary contributions, the Society's only means of support, we can reach out to more and more people with programs for blindness prevention, including:

• Training and support of volunteers in pre-school

vision screenings.

· Conducting community glaucoma screenings to alert those with the disease early enough to save their vision.

- Promoting the use of eye safety glasses in shops and laboratory classes in our schools.
- Educating the public to the importance of safety lenses and frames in all evewear.
- Promotion of standards of safety for all children's
- Encouraging legislation to restrict all fireworks to public displays.
- Constant promotion of eye health and safety in industry through the formation of Wise Owl Clubs in every plant.
- Public education concerning general eye problems, diseases of the eves and the necessity for early detection and treatment of those diseases.

Professional education.

The work of the Ohio Society is carried out by a volunteer board of directors, a medical advisory committee, five permanent staff members and thousands of volunteers throughout the state. Programs are sponsored by civic groups within the state (e.g., Lions, Delta Gamma Alumnae, P.T.A.). All of the programs are under close medical supervision in conjunction with state and local health departments.

Pamphlets, posters and other educational material, along with films, are always available, and staff members and volunteers give lectures and offer advisory services to any interested individual or group.

Statewide services are channeled through the state office, 1500 West Third Avenue, Columbus, with volunteer program coordinators assisting in all areas of Ohio. A part-time executive secretary in Dayton coordinates all blindness-prevention activities in a seven-county area under the guidance of an area branch board.

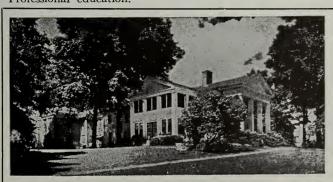
The Ohio Society is an affiliate of the National Society for the Prevention of Blindness, Inc. which, as the second oldest national voluntary health agency in the country, and the only national health agency existing solely for blindness prevention, celebrates its 67th birthday this year.

The Ohio Society has shown phenomenal growth in its program services in the past few years. But its financial growth has lagged behind and until this year it has had to rely on a subsidy from the National Society. It is supported entirely by voluntary contributions with no government or United Way assistance. To meet the increasing demands for its services and to expand its programs, it must achieve increased financial support.

As long as people continue to function unaware of how precious the gift of sight is, there will be an urgent need for the Ohio Society. We must make everyone realize how important vision is and how easily it can be lost forever.

"Lord, that we all might see."

-Ohio Society for the Prevention of Blindness



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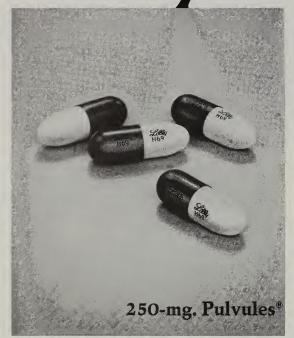
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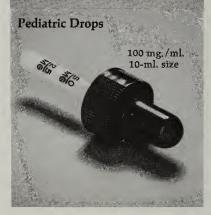
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Evaluation of the Use of Computer-Assist Electrocardiographic Readings in a 700-Bed General Hospital

Don C. Nouse, M.D.

This paper presents evidence that a computer-assist ECG program offers advantages to the delivery of medical care. A major gain is increased efficiency of recording and early return of interpreted records for chart use. Another factor is that the presently available computer programs have an accuracy acceptable for emergency interpretation.

Normal interpretations are nearly 100-percent accurate. The more difficult interpretations require physician overreading.

A computer-assist program reduces physician-required time by 50 percent. Future use can be extended to physicians' offices and small hospitals, where trained cardiologists are not

be extended to physicians offices and small indispirals, where I talked caldiologists are not readlly available; overreading then can be done at central hospitals. These programs can eventually reduce the unit cost of electrocardiograms to the health care system.

Editor's Note: The increasing use of computer interpretation of electrocardiograms emphasizes the need for physician education and awareness of the continuing change in computer reliability. R.L.M.

THE ECG DEPARTMENT at The Toledo Hospital 1 has been associated with the Cro-Med® computerassisted ECG interpretation since August 1, 1973. The case load approaches greater than 18,000 ECGs yearly. Our major concern was to ascertain if this program was of value in an institution with available and qualified cardiology personnel. Our secondary interest was evaluating the quality of the computer's interpretation of the ECGs.

We were most impressed with the professional physician management of this program. Dr. Leon Pordy* and his associates at Mt. Sinai Hospital in New York City were most helpful in this cooperative venture. Before starting this program, Dr. Edward Massie† of Barnes Hospital in St. Louis was visited. At that time, he was investigating the Cro-Med program.

Hardware Required

Hardware required for this program is a threechannel ECG console with telephone transmission, patient cables, teletype printer, telephone lines, and a tape recorder for batch reading. The software includes paper, electrodes, mounting cards, and ECG paste.

This hardware is similar to a three-channel Marquette-type electrocardiographic recording machine except for the tape recorder and the teletype printer, the latter being rented from the Bell Telephone Company. The software again is similar to that required for standard simultaneous three-lead electrocardiography. The great advantage in this is that the ECG paper-mounting technique can be done at the bedside. A copy is left at the bedside and, therefore, is immediately available for physician use.

Procedures

After the electrocardiogram has been completed, the ECG, cart, and tape decks (figure) are returned to the central cardiac station and then transmitted by a direct line to the computer. The ECG signal is demodulated and converted to a digital value for telephone transmission.

^{*}Director of Electrocardiography, Mt. Sinai Hospital, New

[†]Professor of Clinical Medicine, Washington State University, and Director of Heart Station, Barnes Hospital, St. Louis, Mo.

Digital values for length of ECG are analyzed by the computer. Twenty seconds of cardiogram data are exposed to 15,264 separate digital values. For the diagnosis, the computer recognizes the waves (P, QRS, T), identifies them, classifies them with each other, and measures the most representative group of waves. The computer then applies diagnostic medical criteria to the measurements to arrive at a diagnosis.

This data is returned to the hospital over an ordinary telephone line from the computer to an ASR-33 teletype unit at the hospital. Automatically, the message identifies by type-out: the patient number, date recorded, date processed, rhythm, rate, PR interval, QRS interval, diagnosis, and contour diagnosis in a form suitable for mounting on the patient's record.

This strip information is then mounted on the representative ECG copy and is available for physician overreading. It is compared with prior ECGs when available and a full official report is placed on the patient's chart.

Problems

The initial problems of equipment change and personnel training were under the guidance of Cro-Med. The success of this program depends on the quality of the records, and this initial step is fundamental. Without additional personnel, house and emergency service was extended to 12 additional hours daily.

Telephone transmission was an initial problem, but bypassing the hospital switchboard by a direct line and altering transmission have solved this problem. Teletype returns have been most satisfactory.

Only 94 computer diagnoses were challenged between January 1, 1974 and May 1, 1974. These were from a total of more than 6,000 ECGs. Five were typist errors on the teletype return.

In reviewing the major problems and difficulties with the computer system, the missed diagnosis of true posterior infarctions seems to be the most commonly missed diagnosis. There were six such missed diagnoses of infarction. Since this has been reported, a change has been made in the criteria and, in the future, these will be diagnosed as possible true posterior wall infarction. In two instances, there were anteroseptal infarctions diagnosed which later proved to be due to lead placement. This could also happen in a noncomputer program. In four cases, inferior wall infarction was diagnosed by the computer and this was not present. In two instances, acute myocardial infarction was present by configuration of the ST segment and later diagnosed by the computer. The electrocardiographer promptly identified these infarctions and the possibility was noted on the report. One 26-year-old patient with T-wave changes over the anterior

Dr. Nouse, Toledo, Chief of Cardiology, The Toledo Hospital, Toledo, Ohio. Submitted September 27, 1974.



Electrocardiograph, card, and tape decks used in the Cro-Med® ECG interpretations.

wall leads was incorrectly diagnosed as having myocardial infarction.

In no case was the intermediate or postacute myocardial infarction missed by the computer diagnosis. All of the other differences and opinions were based on infarctions that were greater than six weeks old and where the electrocardiographer had available records for comparison. As a summary of our experience in diagnosing myocardial infarctions, with the exception of the true posterior wall infarction, the computer does an excellent job in suggesting or diagnosing myocardial infarction.

Differences in diagnosis of arrhythmias were minor and, where adequate records were made available to the computer, there were no serious differences noted in the electrocardiographic diagnosis.

We believe this emphasizes the need for continued physician overreading. The comparison with prior records is an important physician function.

The need for physician overreading is necessary. Cro-Med presented this as a necessity, and this had a bearing on our decision to try this computer program.

The remaining discussion is related to our observations in this concern.

Discussion

We did not attempt to record our unified differences with the interpretations until we were well acquainted with the criteria data that the ECG department at Mt. Sinai Hospital and Cro-Med were using. All differences were discussed with Dr. Pordy and his staff. As we became aware of the computer criteria and deductive priorities (greater than 24 for left bundle branch block), we quietly recorded our differences.

These have been listed only where we thought one patient's treatment on the basis of ECG interpretation would be altered. Criteria such as T-wave changes and differences in axis alterations were not included.

Emergency transmissions can be done at any time with the minimal additional costs, and are returned within 6 minutes. Usually, the tracings are batched—with first transmission at 10 AM and the last at 11 PM. Our laboratory finds this arrangement most satisfactory.

We believe additional values can be derived by smaller hospitals where qualified electrocardiography interpretation is not available immediately.

A necessary part of this program must include a disciplined, well-motivated ECG staff. The computer room personnel requires frequent prompting and prodding to fulfill their return data obligations.

The equipment problems are infrequent. Service for repairs has been both prompt and effective. One extra complete cart unit is available within the hospital for replacement of any breakdowns. We are presently utilizing five carts for nearly 80 electrocardiograms daily. In relation to axis and specific intervals, we are well aware now that the computer can do a better job in evaluating these than can direct physician reading.

In general, the future of computer-assisted programs seems more than bright. The greatest problem is insufficient case load, to decrease the unit ECG cost. Physician and hospital acceptance of this program has been very gratifying.

The availability of preoperative records the day before surgery has aided in the prevention of early morning cancellation of surgery due to ECG findings. The panel has scheduled the overreading at three times—7 AM, 12 noon, and 6 PM—on the basis of transmission time. One visit to the ECG station is all that is necessary.

On the basis of physician time saved and scheduling alone, this program eventually will be justified. The physicians have used their interpretation fees to underwrite this investigation.

The ECGs are available on the charts immediately after recording, and interpretations are on the charts a few hours after being done. Thus, the lag of transcription, typing time, and overviewing the type interpretation is circumvented.

The efficiency of the program has reduced the cost of unit ECGs. Records are immediately available for the physician.

The ECG panel members note many positive advantages with this system. The reading times have been halved. All of the calculations of intervals and cardiac rate and configuration are done by the computer. The accuracy of this computer, in these factors, is greater than that of any of the electrocardiographers. We have found few errors in the rhythm diagnoses. Some errors have been due to recording techniques.

In the present era of need for increased efficiency in the delivery of health services, this is an available technique for improving the quality of health care and conserving the physician's time.

Summary

The experience of 18 months of evaluating the computer-assist program of electrocardiographic interpretation has proved the practical value of such a computerassist program. We are impressed with the reliability of electrocardiographic interpretation by computer in approximately 95 percent of the cases. We believe an additional advantage is the marked decrease in physician time required to overread such evaluated electrocardiograms. The computer seems to be correct in over 99 percent of the cases and the diagnosis of normal ECG. In addition to the savings in physician time, technician time is markedly decreased and the efficiency of personnel has greatly improved. We are presently providing 24-hour coverage with computer-assisted electrocardiography. We believe that eventually this system will markedly decrease the unit cost of electrocardiograms.

Acknowledgement: I am grateful to the individuals who assisted in compiling the data for this article, especially Brian Bradford, M.D., F.A.C.C., and Pat Edwards, R.N., The Toledo Hospital, Toledo, Ohio.

Burn Therapy Program in a Community Hospital

Robert K. Finley, Jr., M.D. Vicki Little, R.N.

> The burn therapy program at Miami Valley Hospital in Dayton consists of a physician or physicians concerned with the care of burn patients; a burn therapy room for the administration of special dressings and hydrotherapy; a clinical nurse to coordinate the therapy with other hospital departments; and a nursing staff cognizant of the specific problems of the burn patient.

BURN THERAPY IN THE DAYTON community is administered by general or plastic surgeons in the six area hospitals. In approaching this group of patients, we felt that a more centralized mode of therapy should be considered and might better serve the needs of the community.

At Miami Valley hospital, approximately 50 patients are admitted per year (Fig. 1). There are five other area hospitals of comparable size in this community, and 150 burn patients are hospitalized in this area per year. The surrounding area hospitals have another 200 burn patients, making a total burn population of about 300 per year. Most of these are cared for in the general hospitals, but some are transferred to special burn units in Cincinnati and Columbus.

Interest in a burn therapy program began here in 1966. A burn unit with a specific number of beds was visualized initially. Numerous areas and wards were considered and other burn units were studied in an attempt idea of reserving a number of general hospital beds for a specific purpose met with considerable opposition. A visit to other burn units revealed an uneven

to adapt suitable plans for our institution. The demand for hospital beds in our community is so great that the

occupancy of the beds. Beds were empty at times and were filled to capacity at other times. The hospital administration was cool toward the idea of having a specialized unit which would take up a certain number of beds that would not always be filled. The solution lay in developing a burn therapy program. No specific beds would be held for burn patients, rather, all beds would be considered for such patients. The burn therapy program would be directed by one or more physicians interested in burn therapy and coordinated by a clinical burn nurse.

General nursing care would be given on the floor to which the patient would be assigned, while special burn care would be administered in the burn treatment room. This special burn care consists of burn dressings twice a day, using a hydrotherapy tank, and sterile techniques. After the dressings are changed, the patient is returned to his bed and then taken back to the nursing station. Once this policy and plan were adopted and agreed upon, it was then necessary to construct a burn therapy room.

Construction

Construction of such a room required several considerations. It should be convenient and close to the patient-care areas which might actively be treating burn patients. Space should be adequate for a therapy tank with plumbing and working space around it, a dressing table with the same requirements, and room for a bed in which the patient could be transported into the area. Area for counters, sink, and cupboards (at least on three sides) would be desirable. The floor covering should be simple, waterproof, and easily cleaned. The ceiling should be high enough to allow adequate clearance for a circleelectric bed, or a bed with traction apparatus on it, to

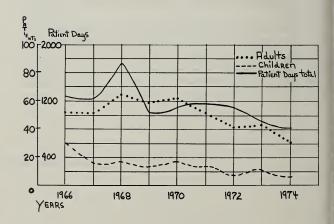


Fig. 1. Burn patients treated at Miami Valley Hospital from 1966 through 1974.

Mrs. Little, Dayton, Burn Clinical Nurse, Miami Valley Hospital.

Submitted March 14, 1975.

Dr. Finley, Dayton, Staff Member, Kettering Medical Center, Good Samaritan, and St. Elizabeth hospitals; Consultant, Veterans Administration Hospital, Dayton; Instructor in Surgery, The Ohio State University College of Medicine; and Clinical Professor of Surgery, Wright State University School of Medicine.

clear an overhead lift on a track. The lighting should be good with an intense light for débridement and minor procedures such as tracheostomy, cutdowns, and insertion of central venous pressure lines.

Many types of air treatment equipment were considered and, finally, a laminar flow system with a high efficiency filtration (99.97 percent) of particulate matter was chosen. This provides an even flow of air over a wide distribution from one wall behind the treatment tank toward the bed. No drafts or eddies are produced with this system. The air is then refiltered and recirculated after particulate matter, over 0.3 micron in size, is removed. This equipment adds to the humidity of the air and controls the temperature quite accurately. It is comparable to the air treatment equipment recommended for operating rooms.

The final plan is shown in Figure 2. The overall dimensions are 20 X 21 feet. The ceiling is 8½ feet high, and the overhead lift is on a track with an electric hoist for the stretcher with enough clearance to go under the light. As the room was previously a kitchen, a terrazzo floor was in place, and serves very well as a nonporous floor that is easily maintained.

Operation

The wide door permits the patient to be brought into the therapy room in bed. He is transferred to a stretcher which is then attached to the overhead lift and then transferred to a dressing table by sliding it on the track. The loose dressings are removed and those adherent to the wound are left in place to be removed in the tank. The lift again is used to transport the patient gently into the filled hydrotherapy tank. With the agitator, the hydrotherapy tank removes the remaining dressings and the eschar in a gentle and comfortable manner. After a period of 10 to 20 minutes of hydrotherapy, the patient is lifted back onto the dressing table while remaining on the stretcher. The topical dressings are applied, he is returned to the bed, and the bed is moved back to the room where he is cared for by the regular floor nurses. Using a closed technique relieves some of the need for isolation techniques and increases the ease of nursing care. The entire treatment can be accomplished by two persons in 30 to 60 minutes, depending on the extent of the burns.

Emergency admissions are received in the emergency department where vital care is given. The patient is transferred then to the burn therapy room where the wounds are débrided, cleansed, and dressed.

Staffing

The burn treatment room is staffed with registered nurses who are hired and trained specifically to perform skilled procedures on the burn patient. The qualifications include at least one year of working experience, preferably

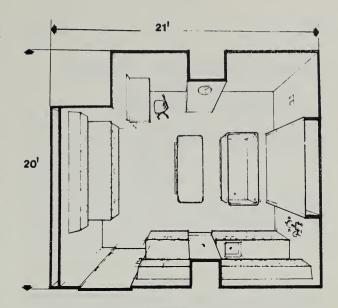


Fig. 2. Plan of burn treatment room at Miami Valley Hospital.

in the critical care area but not necessarily with burn patients. The most important quality is an emotionally mature nurse who can work under the stress that the burn patient presents. The stresses are due to the longevity of hospitalization and the painful nature of the injury.

The nurses are directly responsible to the clinical burn nurse, who coordinates total burn care between hospital departments and who supervises the treatment room. They must have a thorough knowledge of all aspects of burn care with special emphasis on wound and dressing care. Their responsibility is the twice-daily hydrotherapy and dressing changes. They are adept in the mechanical débridement of nonviable skin and the application of bacterial agents or biologic dressings to the burn wound.

In the event there are no burn patients in the hospital, these nurses "float" to other areas of the hospital, mainly to critical care areas where they can assist with staffing needs and retain their own clinical expertise.

Conclusion

The burn treatment program in our hospital consists of: (1) a physician or physicians interested in the care of burn patients; (2) a burn therapy room where special dressings and hydrotherapy care can be administered; (3) a clinical burn nurse who coordinates the therapy with the other hospital departments; and (4) a nursing staff familiar with the specific problems of the burn patient.

Immunosuppressive Therapy in Rheumatic Diseases

A Retrospective Study

Marvin H. Thomas, M.D. Waldemar Bergen, M.D. Vol K. Philips, M.D. Norman O. Rothermich, M.D.

> Seventy-nine patients with various rheumatic disorders received 106 trials with one or more immunosuppressives. Nearly 50 percent showed significant short-term improvement although only a few remained on active drug therapy for a variety of reasons. Serious short-term side effects were surprisingly few, but the long-term hazards remain unknown and may limit the usefulness of these medications.

MMUNOSUPPRESSIVE THERAPY in the rheu-1 matic diseases dates back to the 1950s when aminopterin and nitrogen mustard were used. Since that time, various reports have appeared in the literature detailing successes with azathioprine, cyclophosphamides, and chlorambucil. Many of these were uncontrolled and left the place of this form of therapy uncertain. The Cooperating Clinics Committee of the American Rheumatism Association studied high- versus low-dose cyclophosphamide therapy in a controlled fashion.1 They found high dose to be efficacious. Urowitz, et al reported another controlled trial using azathioprine, and they concluded the drug in doses of 2.0 to 2.5 mg per kilo per day over 16

weeks was superior to placebo.² Levy, et al noted similar results over a six-month period.3

We have recently reviewed our data with immunosuppressive therapy over the past nine years. While it is a retrospective study with obvious limitations, certain trends seemed to emerge which prompted us to report our findings.

Materials and Methods

Seventy-nine patients received 106 trials with one or more immunosuppresive. The three drugs used were azathioprine (Imuran®), chlorambucil (Leukeran®), and cyclophosphamide (Cytoxan®). Fifty patients received chlorambucil, 36 azathioprine, and 10 cyclophosphamide. Some received these drugs on more than one occasion and were considered as two separate trials. Most of this data includes patients seen from 1968 to the present, although it does also include results of a previously reported trial with azathioprine (22 patients).4 All patients had either classical or definite rheumatoid arthritis according to the criteria of the American Rheumatism Association,⁵ with the exception of four patients who had ankylosing spondylitis, psoriatic arthropathy, scleroderma, and systemic lupus erythematosus, respectively. The duration of disease averaged 9.2 years with a range of 1 to 32 years. The duration of therapy with these drugs averaged ten months, with a range of 1 to 46 months. Those receiving cyclophosphamide had the shortest trial period, averaging 5.5 months with a mean of three months.

Our arbitrary parameters of improvement were:

- 1. Seventy-five percent or more reduction in initial steroid dose.
- 2. Reduction of duration of morning stiffness to 30 minutes or less.
 - 3. Elimination of nocturnal joint pain.
 - 4. No active inflammation on joint examination.
 - 5. The patient's affirmation of drug benefit. 6. Physician's affirmation of drug benefit.

Dr. Thomas, Columbus, Attending Staff, Riverside Methodist, and Mt. Carmel Hospitals; and Associate Clinical Professor of Medicine, The Ohio State University College of Medicine.

Dr. Bergen, Columbus, Attending Staff, Riverside Methodist, Mt. Carmel, and The Ohio State University Hospitals; and Associate Clinical Professor of Medicine, The Ohio State University College of Medicine.

Dr. Philips, Columbus, Attending Staff, Mt. Carmel, Riverside Methodist, and The Ohio State University Hospitals; Consulting Staff, Children's, and Rickenbacker Air Force Base Hospitals; and Associate Clinical Professor of Medicine, The Ohio State University College of Medicine.

Dr. Rothermich, Columbus, Attending Staff, Mt. Carmel Hospital; and Clinical Professor of Medicine, The Ohio State University College of Medicine.

We felt that five of these six criteria should be met to include patients in the "marked improvement" category, while fulfillment of three of the six criteria satisfied inclusion in the "moderate" benefit category.

Results

Of the 54 trials with chlorambucil, 20 were felt to qualify as showing marked improvement, with steroid dosage reduced by 75 percent in six. Five were considered to show moderate improvement, six were too brief to evaluate, and 23 were felt to show no improvement. Only five patients continue to receive this drug now. The reasons for discontinuation were: no benefit (ten patients), remission (three patients), hospitalization (nine patients), low white blood cell count (two patients), and other toxicity (13 patients). Two patients on chlorambucil have died secondary to profound leukopenia and sepsis. Three patients were lost to follow-up and three simply felt uneasy about the use of the medication. Of the 13 definite toxicities, six were dematologic (five of which were herpes zoster). Three had hematologic abnormalities, four had gastrointestinal intolerance, primarily nausea. In the original azathioprine study, 16 of 22 patients were recorded as showing moderate-to-marked improvement with only five failures. Only four toxic reactions were seen, two of which were gastrointestinal. The later trials of azathioprine, however, record only one markedly successful result, five moderate, and seven with no benefit. In the original azathioprine study, ten patients had a 75-percent reduction of steroid dosage, while in later trials, this was accomplished in only one patient. Five toxic reactions were seen in the later trials with azathioprine, four of which were gastrointestinal. Four patients remain on active drug status. Ten patients received 11 trials with cyclophosphamides. Two were recorded as showing marked improvement and two moderate benefit. Four were felt not to be improved, and the trial was too brief in an additional four. Two patients had reduced white blood cell counts, leading to cessation of the drug; three were recorded as having definite toxicity: one skin, one hematologic, and the other cystitis.

Of the 79 original patients started on these drugs, ten currently remain on them. Among the reasons for stopping the drug were: 18 patients reported no benefit; eight were lost to follow-up; 12 entered the hospital for surgical procedures and it was felt prudent to stop the medication; three were felt to have a full remission, 11 concluded the original Imuran® trial and were not followed further; four had a low white blood cell count, but not definitely considered toxic; four had questionable toxic side-effects; 11 had "variable reasons," such as

Presented before the Ohio Rheumatism Society Meeting, September 7, 1974, Salt Fork Lodge, Cambridge, Ohio. This study was supported by the Columbus Medical Center Research Foundation, Columbus, Ohio. Submitted November 27, 1974.

myocardial infarction, unrelated rash, "uneasy feeling about the drug"; and 25 were felt to have definite toxicity.

Discussion

The place of immunosuppressive drugs in the treatment of connective tissue diseases remains uncertain. Ultimately the answer will depend on carefully designed and executed controlled trials. In fact, just how they alter the disease processes remains somewhat controversial. Diminution in lymphocyte populations, both T (thymus-dependent) and B (bone-marrow-dependent) cells, with subsequent decrease and alteration of both humoral and cell-mediated immune responses have been shown. Subsequent changes of antigen-antibody formation could be expected to occur with the consequent decreased stimulation of the inflammatory response. Primary alteration of leukocyte function also may be involved leading to a lessened contribution by leukocyte lysozymes to inflammation. While the mode of action remains in part speculative, these drugs are being used in rheumatology and experience with them has started to accumulate. Many rheumatologists feel that their role at this point should be reserved as a "last ditch" approach when more conservative modalities, including acceptable corticosteroid doses, have failed. Others feel that they have an earlier and more primary use. The former view seems most reasonable at this time. Use of these drugs requires knowledge of their actions and side-effects and should not be prescribed in a casual manner. Written informed consent is considered mandatory. While controlled studies will, in time, give us more precise rationale and guidance, retrospective studies such as this point out important emerging trends. Approximately 50 percent of our patients were felt to have gained a significant degree of improvement; however, the length of time was admittedly short. It is of interest that at the time this study was undertaken (summer of 1974), only 10 patients out of 79 remained on active drugs. There were many reasons for abandonment including toxicity (25 instances); hospitalization for various reasons (12); definitely no benefit (18); and "other" which included various categories. Nonetheless, even though improvement was felt to be present in a relatively large number, the fact remains that, for one reason or another, these drugs were discontinued in a very substantial percentage, either by the physician or by the patients themselves. This experience is shared by other centers. Part of this may be the fear of a potent drug used in new circumstances. In the short run, the problems with these drugs were surprisingly few. Lowered white blood cell counts were frequently seen and at what level we call this toxicity remains uncertain, but values below 3000 per cu mm seem hazardous. We did record two known instances of severe leukopenia with consequent infection and death but, aside from these, the incidence of infection was low. The more frequent occurrence of herpes zoster with chlorambucil has somewhat tempered our use of that drug. We saw only 25 definite toxic episodes, although other questionable prob-

lems were encountered. Of these 25 episodes, ten were gastrointestinal disturbances that were easily reversible. Thirty-seven percent of the trials resulted in no benefit and 15 percent were felt to be too brief for any conclusions. While the short-term problems were lower than anticipated, we know very little about the long-range effects. This is particularly true of the role these drugs will play in altering immune surveillance with the possible eventual appearance of increasing number of neoplasms. Additionally, we know cyclophosphamide and chlorambucil interfere with spermatogenesis and ovarian function and the ultimate effects on chromosomes and congenital defects remain a concern. Nonetheless, it would seem to us that these potent drugs do have a place in the treatment of various rheumatic diseases under strict controls including written informed consent of the patient. The precise boundaries remain unknown at this time and await more definite controlled studies. Their use must be tempered with knowledge of their potential and the use of critical judgment in their proper selection.

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Maternal Deaths Following Unattended Delivery

By the OSMA Committee on Maternal Health*

OUR TEACHING in obstetrics today includes the proper management of spontaneous, assisted, and operative deliveries — premature, at term, and post-term — where fetuses of all sizes are the "passengers." In the current literature as well as in the popular textbooks on obstetrical practice, there is little or nothing written about unattended, spontaneous, term delivery.

In the past, we have listened with a gullible ear to the old wives' tales concerning women who interrupted their daily chores long enough to deliver their baby and promptly returned to the completion of their task at hand. Yet the older annals failed to record the *final* outcome of either the newborn baby or its mother.

Herein, the Committee presents a report of four maternal deaths following *unattended* delivery of the term fetus.

A 22-year-old, white woman was discovered dead in a motel with a recently delivered, dead, term-sized infant with attached umbilical cord and placenta. Nothing was known of the patient's past history, the pregnancy, or the circumstances related to the patient's labor and delivery. It is assumed the

delivery was spontaneous and unattended and that the fetus suffered neonatal death.

Cause of Death (Coroner's Autopsy): Exsanguination, uterine hemorrhage; childbirth unattended; lacerations of cervix, fourchette, and intrauterine hemorrhage.

A 31-year-old white, Para V, died a few hours following spontaneous, unattended, term delivery at home. Past history includes four previous pregnancies without complications. She had no prenatal care. Apparently the spouse had no knowledge of her last pregnancy, which she allegedly concealed for reasons unknown. Likewise, her physician denied any knowledge of her pregnant state, declaring she was an ideal patient previously. On returning from work one evening, the husband found his wife ill, in bed, and the area was heavily blood-stained. His wife declared she was having a miscarriage and that she had contacted her physician, who instructed her to rest and visit him the next day. (This was not confirmed.) Temporarily reassured, the husband descended the stairs to continue his dinner. Later on, he went upstairs to investigate his wife's progress and while en route, he heard the cry of a baby. On entering the bedroom, he found a baby loosely wrapped in towels, his wife highly excited and incoherent. After a quick call to their physician, the patient and baby were transported to the hospital. The baby was in excellent condition but its mother was pulseless, lifeless. There was local evidence of heavy vaginal bleeding.

Cause of Death (Autopsy): Antepartum, intrapartum hemorrhage, exsanguination; unattended, concealed or unsuspected term pregnancy, and spontaneous home delivery; placenta previa (partially attached); cholelithiasis; parovarian cyst left, twisted pedicle.

A 19-year-old, white, married, Para III delivered spontaneously, unattended, at home. Details of the past history (and previous pregnancies) are not known. She made several visits to her physician in the time of the last pregnancy, during which she had "false labor," was admitted and discharged not delivered,

^{*}A continuous statewide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association in cooperation with the Ohio Department of Health and representatives of the various County Medical Societies. Summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published here from time to time, interspersed with statistical summaries.

details of which are not recorded. Later, spontaneous, premature labor began at home and the patient quickly delivered a small, stillborn fetus on the commode. The placenta was retained, postpartum hemorrhage and shock ensued, and the patient was admitted to the hospital. She was in poor condition, febrile and "shockey." Consultation was obtained. The diagnosis: septicemia, with disseminated intravascular coagulation, probably secondary to delivery. Parenteral fluids, whole blood, massive antibiotics, delivery of placenta and membranes followed in the critical days of the puerperium which followed. In spite of intensive care, the patient pursued a downhill clinical course and died.

Cause of Death (Coroner's Autopsy): Septicemia, bacterial endocarditis (Staphylococcus aureus) following unattended delivery; vegetations of aortic, mitral, and tricuspid valves; septic emboli to arteries of myocardium; patchy organizing pneumonia; multiple organizing abscesses of brain; organizing septic infarcts

of lungs, kidneys, and spleen.

A 30-year-old, obese, white Para II died a few hours after spontaneous, unattended delivery of a large, living baby at home. There was no prenatal care; she was always obese; and no complications were reported on her previous pregnancy and delivery. Early one morning, her husband discovered her on the bathroom floor unconscious! The (big) baby was alive, lying between her thighs, still attached to the cord. The placenta was still intrauterine; she was hemorrhaging profusely. In the ambulance en route to the hospital, the patient had a convulsion. She was in shock, developed cardiac arrest, was on the respirator, received external cardiac massage, and began to breathe. At this point, the placenta was removed manually and clitoral and vaginal lacerations were repaired (no anesthesia). The uterus was reported intact; she received much medication including whole blood. Transferred to intensive care, she never regained consciousness and died the same day.

Cause of Death (Autopsy): Shock and cardiopulmonary arrest; pregnancy delivered unattended at home with severe postpartum hemorrhage; retained placenta; cerebral anoxia.

Comments of Consultant

The following comments of a Consultant who specializes in obstetrics and gynecology was given at the request of the Committee:

"I note that the Committee has not commented directly on each of the four tragic deaths presented. Obviously, the facts and features (like the old Victrola) speak for themselves!

"Strangely enough, in every report, there are some 'mysterious' features which will remain obscure. Nor would these clarify or justify the cause of death, listed by the pathologists, in any instance. The last three reports contain this frustrating element, especially in view of the fact that the patients were multiparas and were married. Unfortunately, the meager information obtained by the Committee (with probable maximum effort) provides little toward clarification of the enigma.

"Perhaps the only paltry panacea which this consultant can offer is ideal prenatal care, so carefully covered in the Committee's document, 'Guiding Principles for Obstetric Care.' Direct communication and instruction from the obstetrician ranks high in the prevention of many maternal deaths, such as the four presented in this article."

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Ohio Health News

John H. Ackerman, M.D., M.P.H.

Director of Health

Public Health Rules On Abortion

In September 1974, enabling legislation was passed requiring the Public Health Council to establish rules for abortions performed in Ohio. After holding hearings, the Public Health Council adopted the following rules, which became effective September 1, 1975.

HE-4-01. Definitions.

As used in rules HE-4-01 to HE-4-07, inclusive, of the

Ohio Sanitary Code:

- (A) "Abortion" means, as defined by section 2919.11 of the Revised Code, the purposeful termination of a human pregnancy by any person, including the pregnant woman herself, with an intention other than to produce a live birth or to remove a dead fetus or embryo. Abortion is the practice of medicine or surgery for the purpose of section 4731.41 of the Revised Code.
- (B) "Conceptus" means the product of human concep-
- (C) "Department" means the Department of Health of the State of Ohio.
- (D) "Director" means the Director of Health of the State of Ohio.
- (E) "Fetus" means the developing conceptus from fourteen (14) weeks after the first day of the woman's last menstrual period until birth.

(F) "Gestation" means pregnancy.

(G) "Hospital" means any building, structure, institution, or place devoted primarily to the maintenance and operation of facilities for the diagnosis, treatment, and medical or surgical care for three or more non-related individuals, suffering from illness, disease, injury or deformity, and regularly making available at least clinical laboratory services, and diagnostic X-ray services and treatment facilities for surgery or obstetrical care, or other definitive medical treatment. It does not include a "home" as defined in section 3721.01 of the Revised Code.

- (H) "Pathologist" means a physician licensed to practice in Ohio with special training in the pathology of tissues.
- (I) "Post-abortion care" means care given after the uterus has been evacuated by abortion.

HE-4-02. Post-abortion procedures.

In all abortions upon a woman whose conceptus, in the best judgment of the attending physician is a fetus as defined in rule HE-4-01, the physician shall effect compliance with the following:

(A) Immediate post-abortion care shall be provided

in a hospital.

(B) Written and oral discharge instructions shall be issued to each woman which shall include, but not be limited to, the following:

(1) Symptoms of complications to be looked for and recommended response to any

such symptoms;

(2) Activities to be avoided:

(3) Notification of a 24-hour emergency ser-

(4) Comprehensive birth control information;

- (5) The date for follow-up or return visit after the performance of the abortion, which shall be scheduled as indicated by the condition of the patient and instructions on the importance of a follow-up visit;
- (6) Use of appropriate medications, when indicated:
- (7) Instructions about the care of her body. (C) Information regarding Rh typing of the patient's blood shall be a part of the patient's medical record. Anti-Rh immune globulin therapy shall be given to all Rh negative patients upon completion of the abortion procedure when medically indicated, except when refused by the patient. If for any reason a patient refuses this therapy, the refusal shall be documented in the clinical record.

(continued on page 644)



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Warnings: Tolerance may develop in some instances necessitating a reevaluation of therapy. Usage in Pregnancy: In view of embryotoxicity findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefit outweighs the potential risk to mother and fetus Usage in Children: No clinical experience is available with the use of Combines in children Precautions: When discontinuing Combipres, reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness. agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of Combipres therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect of the clonidine hydrochloride component. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other antihypertensive agent, Combipres should be used with caution in patients with severe coronary insufficiency. recent myocardial infarction, cerebrovascular

As an integral part of their overall long-term care, patients treated with Combipres should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmological findings have been recorded with Catapres, in several studies the drug produced a dose-dependent increase in the incidence and severity of spontaneously occurring retinal degeneration in albino rats treated for 6 months or longer.

disease or chronic renal failure.

Patients predisposed toward or affected by diabetes should be tested periodically while receiving Combipres, because of the hyperglycemic effect of chlorthalidone.

Because of the possibility of progression of renal failure, periodic determination of the BUN is indicated. If, in the physician's opinion, a rising BUN is significant, the drug should be stopped. The chlorthalidone component of Combipres may lead to sodium and/or potassium depletion. Muscular weakness, muscle cramps, anorexia, nausea, vomiting, constipation, lethargy or mental confusion may occur. Severe dietary salt restriction is not recommended in patients receiving Combines

Periodic determinations of the serum potassium level will aid the physician in the detection of hypokalemia. Extra care should be given to detection of hypokalemia in patients receiving adrenal corticosteroids, ACTH or digitalis. Hypochloremic alkalosis often precedes other evidence of severe potassium deficiency. Frequently, therefore, more sensitive indicators than the potassium serum level are the serum bicarbonate and chloride concentrations. Also indicative of potassium depletion can be electrocardiographic alterations such as changes in conduction time, reduction in amplitude of the T wave; ST segment depression; prominent U wave. These abnormalities may appear with potassium depletion before the serum level of potassium decreases. To lessen the possibility of potassium deficiency, the diet, in addition to meat and vegetables, should include potassium-rich foods such as citrus fruits and bananas. If significant potassium depletion should occur during therapy, oral potassium supplements in the form of potassium chloride (3 to 4.5 gm/day), fruit juice and bananas should

Adverse Reactions: The most common reactions are dry mouth, drowsiness and sedation. Constipation, dizziness, headache, and fatigue have been reported. Generally these effects tend to diminish with continued therapy.

Clonidine hydrochloride: Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abnormalities in liver function tests; one case of possible drug-induced hepatitis without icterus and hyperbilirubinemia in a patient receiving clonidine hydrochloride, chlorthalidone and papaverine hydrochloride. Weight gain, transient elevation of blood glucose, or serum creatine phosphokinase: congestive heart failure, Raynaud's phenomenon: vivid dreams or nightmares, insomnia, other behavioral changes, nervousness, restlessness. anxiety and mental depression. Also rash, angioneurotic edema, hives, urticaria, thinning of the hair, pruritus not associated with a rash: impotence, urinary retention; increased sensitivity to alcohol, dryness, itching or burning of the eyes, dryness of the nasal mucosa, pallor, gynecomastia, weakly positive Coombs' test, asymptomatic electrocardiographic abnormalities manifested as Wenckebach period or ventricular trigeminy. Chlorthalidone: Symptoms such as nausea, gastric irritation, anorexia, constipation and cramping, weakness, dizziness, transient myopia and restlessness are occasionally observed. Headache and impotence or dysuria may occur rarely. Orthostatic hypotension has been reported and may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics. Skin rashes, urticaria and purpura have been reported in a few instances

A decreased glucose tolerance evidenced by hyperglycemia and glycosuria may develop inconsistently. This condition, usually reversible on discontinuation of therapy, responds to control with antidiabetic treatment. Diabetics and those predisposed should be checked regularly. As with other diuretic agents hypokalemia may occur (see Precautions). Hyperuricemia may be observed on occasion and acute attacks of gout have been precipitated. In cases where prolonged and significant elevation of blood uric acid concentration is considered potentially deleterious, concomitant use of a uricosuric agent is effective in reversing hyperuricemia without loss of diuretic and/or antihypertensive activity. Idiosyncratic drug reactions such as aplastic anemia, thrombocytopenia, leukopenia, agranulocytosis, and necrotizing anglitis have occurred, but are rare.

The remote possibility of pancreatitis should be considered when epigastric pain or unexplained gastrointestinal symptoms develop after prolonged administration.

Other adverse reactions which have been reported with this general class of compounds include: jaundice, xanthopsia, paresthesia and photosensitization.

Overdosage: Catapres (clonidine hydrochloride): Profound hypotension, weakness, somnolence, diminished or absent reflexes and vomiting followed the accidental ingestion of Catapres by several children from 19 months to 5 years of age. Gastric lavage and administration of an analeptic and vasopressor led to complete recovery within 24 hours. Tolazoline in intravenous doses of 10 mg at 30-minute intervals abolishes all effects of Catapres overdosage.

Chlorthalidone: Symptoms of overdosage include nausea, weakness, dizziness, and disturbances of electrolyte balance. There is no specific antidote, but gastric lavage is recommended, followed by supportive treatment. Where necessary, this may include intravenous dextrose and saline with potassium administered with caution.

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Recent Advances In The Management Of Cancer; Sept. 10; Fawcett Center for Tomorrow, 2400 Olentangy River Road, Columbus; sponsored by the Ohio Division of American Cancer Society; Acceptable for six contact hours of AMA category 1 credit; \$5 registration fee.

Cancer Symposium; Oct. 2; Good Samaritan Hospital, Cincinnati; Contact: Asst. Administrator's Office, 3217 Clifton Ave., Cincinnati 45220.

Diabetes Seminar; Oct. 8; Fawcett Center for Tomorrow, 2400 Olentangy River Rd., Columbus; Contact: Center for Continuing Medical Education, A352 Starling Loving Hall, 320 W. 10th Ave., Columbus 43210; \$25 registration fee.

Medical Technology; Oct. 10; Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; Acceptable for category 1 credit toward AMA Physician's Recognition Award.

Newer Bacterial And Viral Vaccines; Oct. 14; Fort Steuben Academy of Medicine, 525 N. Fourth St., Steubenville 43952.

Family Practice Refresher; October 20-24; sponsored by Ohio Academy of Family Physicians; Holiday Inn, 328 W. Lane Ave., Columbus; contact: OAFP, 4075 North High St., Columbus, 43214; \$250 for physicians; \$150 for family practice residents; acceptable for 40 prescribed postgraduate credit hours by American Academy of Family Practice.

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Tri-State Orthopaedic Society; Oct. 30-Nov. 1; Fawcett Center for Tomorrow, 2400 Olentangy River Rd., Columbus; Contact: Center for Continuing Education, A352 Starling Loving Hall, 320 W. 10th Ave., Columbus 43210.

Peripheral Vascular Disease Symposium: Oct. 31-Nov. 1; Stouffer's University Inn, 3025 Olentangy River Rd., Columbus; Contact: Center for Continuing Medical Education, A352 Starling Loving Hall, 320 W. 10th Ave., Columbus 43210; \$60 registration fee.

Clinical Problems In Gastroenterology; Nov. 12-13; Cleve-Clinic Educational Foundation, 9500 Euclid Ave., land Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; Acceptable for category 1 credit toward AMA Physician's Recognition Award.

What's New In Pediatrics; Nov. 12; Case Western Reserve University; Contact: S. S. Strassman, M.D., Pediatric Dept., Rainbow Babies and Childrens Hospital, University Circle, Cleveland 44106.

The Critically Injured Patient: Emergency Surgical and Medical Care; November 13, 14, & 15; the Marriott Inn, Cleveland, O. Sponsored by the American College of Surgeons Committee on Trauma and the Department of Surgery, Case Western Reserve Medical School, Cleveland. Fee is \$150 for physicians and \$50 for interns and residents. Contact: the ACS Trauma Division, 55 Erie St., Chicago, Illinois 60611, or Dr. Mark A. Mandel, University Hospitals of Cleveland, 2065 Adelbert Rd., Cleveland, Ohio 44105. Approved for 20 hours of AMA Category 1 credit and 20 hours accreditation of the American Academy of Family Practice.

Urology X-Ray Seminar; Dec. 7-9; Stouffer's Cincinnati Inn; Contact: Arthur T. Evans, M.D., Div. of Urology, University of Cincinnati Medical Center, 231 Bethesda Ave., Cincinnati 45267.

OUTSIDE OHIO

Clinical Allergy For Practicing Physicians; Sept. 26-27; Office of Continuing Medical Education, Washington University School of Medicine, 660 S. Euclid Ave., St. Louis, Mo. 63110.

Electrophysiologic Approach To Diagnosis And Treatment Of Cardiac Arrhythmias; Sept. 29-Oct. 2; American College of Physicians, Registrar, Postgraduate Courses, 4200 Pinc St., Philadelphia, Pa. 19104.

Pathology And Treatment Of Head And Neck Tumors; Oct. 2-4; Contact: Dr. Ki H. Han, United Hospitals Medical Center, 15 S. 9th St., Newark, N.J. 07107.

Oncology — Current Concepts And Future Prospects; Oct. 23-25; Contact: Office of Continuing Medical Education, Washington University School of Medicine, 660 S. Euclid Ave., St. Louis, Mo. 63110.

New Help For Disabled **Physicians**

Ohio physicians disabled by alcoholism, excessive use of drugs, or mental disorders can now turn to an action program designed to help them regain their full effectiveness in delivering medical care. After months of study and planning, OSMA started its program for impaired physicians on July 1.

Ohio is one of only three states in the country to have a formal program helping disabled physicians. The Medical Society of the State of New York and the Michigan State Medical Society have also introduced

programs.

In the last few years, increasing attention has been directed at the existence of troubled physicians whose ability to practice medicine is jeopardized. Approximately 3,600 of the United States' practicing physicians are addicted to narcotics, according to the AMA's Council on Mental Health. Although accurate statistics on alcoholism are not as available, it is a common assumption that almost twice that number drink to excess. Also included in the category of disabled physicians are those who suffer mental disorders caused by the overwhelming pressures of their personal and professional lives, as well as a substantial number of senile physicians.

Suicide is generally accepted to be one of the major behavioral consequences of mental illness. The AMA Council on Mental Health notes that approximately 100 physicians commit suicide every year, a number equivalent to the average medical school graduating class. A study of JAMA's obituary columns from May 1965 to November 1967 revealed that the mean suicidal age was 49, at or near the usual productive peak for physicians.* Abuse of alcohol or drugs was an important factor in twofifths of the cases, and depressive illness was very common.

Many physicians feel they have no confidential source from which to seek assistance when they realize they have a problem. Others do not realize their problem and must be approached by a family member or peer. The latter are often reluctant to become involved.

In December 1974, OSMA's Council approved a recommendation to establish "a rotating advisory committee (from the Committee on Mental Health) to assist in cases involving physicians who find their professional status threatened by mental health problems including alcoholism and drug dependence." Accordingly, four physicians were selected from the Committee on Mental Health to form the Subcommittee on Physician Effectiveness. These physicians represent vast experience and outstanding training in the areas of alcoholism, drug abuse, and psychiatric disorders. Three of the Subcommittee members attended the AMA's Disabled Physician Conference in San Francisco last April.

After intently studying the problem for several months, the Subcommittee concluded that only an action program involving the cooperation of all Ohio physicians could assist colleagues with problems.

(continued on next page).

Disabled Physicians / continued

"We hope to reach the physician before his problem affects his ability to practice," said Milton M. Parker, M.D., Chairman of the Committee on Mental Health. "Ideally, the Subcommittee will intercept the problem before it requires action by the Ohio State Medical Board on the physician's license."

The Subcommittee based its three-tiered action program on six general principles:

- We should be motivated by humanitarian concerns for the public and the impaired physician.
- We should recognize that alcoholism, drug abuse and mental illness among physicians are too often ignored or untreated.
- We should recognize that alcoholism, drug abuse and mental illness are treatable conditions treatment and rehabilitation personnel skilled in these areas have a good success record.
- We should encourage all impaired physicians to seek help and cooperate in treatment at the earliest possible time in order for them to retain or regain full effectiveness to practice.
- We should employ constructive coercion if a physician refuses all offers for assistance at a time when his impairment poses a threat to reasonable delivery of medical care.
- We should employ involuntary coercion where all efforts fail — and the physician's impairment theatens the public or physician's health.

A detailed step-by-step description of the program is given on the facing page. Basically, it calls for an initial telephone call to the appropriate OSMA staff person from a physician who realizes he or she has a problem. The impaired physician will then be contacted by the respective District Liaison Physician (DLP), a member of the Committee on Mental Health practicing in the same councilor district. The DLP will discuss the problem with the physician and encourage him or her to seek appropriate counseling or treatment

Anyone seeking assistance, or peers seeking assistance for colleagues, may initiate the program by telephoning (614) 228-6971 and asking for the Physician Effectiveness Subcommittee staff person.

Each county medical society and hospital staff is encouraged to consider a similar program at the local level. However, the physician's desire for confidentiality regarding his peers, patients and friends in the community often makes the program more desirable at the state level.

As practitioners of the healing arts, physicians more than any other professional group should be prepared to help troubled colleagues. Individual physicians and organized medicine must recognize and exercise their responsibility to provide the highest quality of medical care to all patients.

*Blachly PH, Disher W, Roduner G: Suicide by physicians. Bulletin of Suicidology, National Institute of Mental Health, December 1968, pp 1-18.

OPTION

When the disabled physician himself seeks guidance and referral through OSMA, the following sequence of events

The disabled physician telephones (614) 228-6971 and gives his name, address, and telephone number to the staff member working with the physician effectiveness program. He indicates his desire for medical help.

The staff member or the Subcommittee contacts the respective District Liaison Physician (DLP).

The DLP contacts the physician, inquires about the nature of his illness or problem, and discusses appropriate evaluation and treatment arrangements.

The DLP contacts the psychiatrist or other physician considered most appropriate to care for the disabled physician, and discusses the general nature of the prob-

The sick physician enters treatment with the attending physician, ending OSMA's involvement.

OPTION I

OSMA Subcommittee on Physician Effectiveness District Liaison Physician Attending Physician

OPTION II

Concerned Peer OSMA Subcommittee on Physician Effectiveness District Liaison Physician County Medical Society Attending Physician

OPTION III

Concerned Peer OSMA Subcommittee on Physician Effectiveness District Liaison Physician County Medical Society Attending Physician Ohio State Medical Board

OPTION II

The option also exists for a concerned peer (another physician practicing in the same community) to inform OSMA that a fellow physician might be ill and in need of assistance. In this case, the following sequence of events results:

The concerned peer calls (614) 228-6971 giving his own name, address, and telephone number; the name, address, and telephone number of the colleague whose mental health is considered questionable; and the specific reasons for concern. The initiating physician will be guaranteed subsequent anonymity, although he will be required to identify himself to assure that he is indeed a physician. This minimizes the risk of frivolous or vindictive

The staff member or the Subcommittee

contacts the respective DLP.

The DLP checks with the appropriate individual or committee of the local County Medical Society to determine whether, in the Society's judgment, there is sufficient reason to believe the physician in question is ill. This does not require any initiative on the part of the County Medical Society, but simply confirmation from it that other physicians share the concern that this particular colleague might be ill.

The DLP reports to the Chairman of the Subcommittee that sufficient cause

exists to justify contacting the physician thought to be ill.

The Chairman writes to the physician, explaining the nature of OSMA's program. the general circumstances leading to his letter (preserving anonymity for all in-dividuals involved), and urging the physician to seek appropriate evaluation and treatment. This letter also indicates that the DLP will contact the physician personally to make appropriate arrangements.

The DLP contacts the sick physician and offers to help if any problem exists.

If the physician in question acknowledges his illness and need for assistance, the DLP then makes arrangements with an attending physician to evaluate and

The sick physician then enters treatment as agreed between himself and the attend-

ing physicians.

The only further contact between the attending physician and the DLP is the former's confirmation that the sick physician is indeed undergoing appropriate treatment.

The DLP reports to the Chairman that no further action on OSMA's part is indicated. Thus, no contact is made with the Ohio State Medical Board. The Board is only a sort of "unseen presence" whose existence might influence the sick physician to seek treatment.

OPTION III

In some cases, the physician whose health is in question may deny any illness and refuse suggestions of evaluation or offers of treatment. Under these circumstances, the following sequence of events would occur:

The concerned peer calls (614) 228-6971, giving his own name, address, and telephone number; the name, address, and telephone number of the colleague whose mental health is considered questionable; and the specific reasons for concern. The initiating physician will be guaranteed subsequent anonymity although he will be required to identify himself to assure that he is indeed a physician. This minimizes the risk of frivolous or vindictive calls.

The staff member or the Subcommittee

contacts the respective DLP.

The DLP checks with the appropriate individual or committee of the local County Medical Society to determine whether, in the Society's judgment, there is sufficient reason to believe the physician in question is ill. This does not require any initiative on the part of the County Medical Society, but simply confirmation from it that other physicians share the concern that this particular colleague might be ill.

The DLP reports to the Chairman of the Subcommittee that sufficient cause exists to justify contacting the physician

thought to be ill.

The Chairman writes to the physician, explaining the nature of OSMA's program, the general circumstances leading to his

letter (preserving anonymity for all individuals involved), and urging the physician to seek appropriate evaluation and treatment. This letter also indicates that the DLP will contact the physician personally to make appropriate arrangements.

The DLP contacts the sick physician and offers to help if any problem exists.

If the physician in question denies any illness or refuses assistance, the DLP reports this to the Chairman. Similarly, if the physician in question agrees to see the attending physician, but does not do so, a report of this action is made.

After a suitable interval, the Chairman again writes to the physician in question, urging him to seek assistance. The letter points out the Subcommittee's responsibility to report the situation to the Ohio State Medical Board if no corrective action is taken voluntarily.

The DLP follows with telephone contact, stressing the same points as the Chairman.

If the physician in question still denies illness or declines assistance, the DLP again reports to the Chairman. Then after discussion and agreement among the Subcommittee as a whole, the Chairman communicates the facts of the case to the Ohio State Medical Board, preserving the anonymity of the original concerned peer and of specific individuals contacted by the DLP in the local County Medical Society. OSMA's involvement ends at this point.

643

Abortion Rules / continued

HE-4-03. Reporting forms.

- (A) "Abortion report" in this rule means a form completed in compliance with division (C) of this rule.
- (B) The Department shall be responsible for collecting and collating abortion data reported to the Department as required by this rule.
- (C) An individual abortion report for each abortion performed upon a woman shall be completed by her attending physician. The report shall be confidential and shall not contain the name of the woman. This report shall include, but not be limited to the following, in so far as the patient makes the data available which is not within the physician's knowledge:
 - (1) Patient number;
 - (2) Facility name and address;
 - (3) Date of abortion;
 - (4) Zip code of residence of pregnant woman;
 - (5) Age of pregnant woman;
 - (6) Race;
 - (7) Marital status;
 - (8) Number of previous pregnancies;
 - (9) Years of education;
 - (10) Number of living children;
 - (11) Number of previously induced abortions;
 - (12) Date of last induced abortion;
 - (13) Date of last live birth;
 - (14) Method of contraception at time of conception
 - (15) Date of last menstrual period;
 - (16) Medical condition of the woman at the time of the abortion;
 - (17) Rh type of pregnant woman;
 - (18) Type of abortion procedure;
 - (19) Complications by type;
 - (20) Type of procedure done after the abortion;
 - (21) Type of family planning recommended;
 - (22) Type of additional counseling given;
 - (23) Signature of attending physician.
- (D) Abortion reports shall be submitted by the hospital to the Department within fifteen (15) days after the discharge of the woman.
- (E) Appropriate certificate of birth shall be made out after the twentieth (20th) week of gestation.
- (F) A copy of the abortion report shall be made a part of the medical record of the patient of the facility in which the abortion was performed.
- (G) Each hospital shall file monthly and yearly (Fiscal year: July-June) reports listing the total number of women who had undergone a post-twelve-week gestation abortion and received post-abortion care. These reports shall be filed within thirty (30) days following the end of the reporting period.
- (H) Each physician providing post-abortion care to a woman shall report the date of the abortion, name of the facility in which the abortion was performed, the post-abortion complications being treated (if

any), and the duration of treatment. The report shall be made upon a form prescribed by the Department and shall be signed by the attending physician.

HE-4-04. Pathological reports.

In the event a physician finds cause to have a pathological examination performed, then he shall order and obtain the same.

HE-4-05. Humane disposition of the product of conception.

- (A) The fetus shall be disposed of in a humane manner.
- (B) No person shall experiment upon or sell the product of human conception which is aborted. Experiment does not include autopsies pursuant to sections 313.13 and 2108.50 of the Revised Code.

HE-4-06. Counseling.

- (A) The fact of the availability of both preabortion and post-abortion counseling for herself and other persons of her choosing shall be made known by the physician, to each woman who is seeking the abortion of a fetus.
- (B) Counseling shall be non-judgmental, regardless of the circumstances of the pregnancy, but shall not be forced upon the woman.
- (C) The woman shall be treated in a safe, humane and dignified manner during the counseling period and throughout her stay at the place where the abortion is performed.

HE-4-07. Independent Rules.

Each rule of rules HE-4-01 to HE-4-06, inclusive, of the Ohio Sanitary Code is hereby declared to be an independent rule, and the holding of any rule or part thereof to be unconstitutional, void, or ineffective for any cause shall not affect the validity or constitutionality of any other rule or part thereof.



main purpose of drug information for the patient is to get his cooperation in following a drug regimen.

Preparation and distribution of patient drug information

We would hope to amass information from physicians, medical societies, the pharmaceutical industry and centers of medical learning. The ultimate responsibility for uniform labeling must, however, rest with the Food and Drug Administration. There is nothing wrong with this agency saying, "this information is generally agreed upon and therefore it should be used," as long as our process for getting the information is sound.

Distribution of the information is a problem. In great measure it would depend on the medication in question. For example, in the case of an injectable long-acting progesterone, we would think it mandatory to issue two separate leaflets—a short one for the patient to read before getting the first shot and a long one to take home in order to make a decision about continuing therapy. In this case, the information might be put directly on the package and not removable at all. But for a medication like an antihistamine this information might be issued separately, thus giving the physician the option of distribution. This could preserve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

Realistic problems must be considered

We have to expect that the introduction of an information device will also create new problems. First. how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chemical and such types of material should not be included. And there is

no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects: his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively: other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

Only the doctor can remove that fear by 20 or 30 minutes of conversation.

I'm not suggesting that we withhold any information from the patient because, first of all, it would be totally dishonest and secondly, it would defeat the very purpose of the insert. I do think that a patient on the birth control pill should know about the incidence of phlebothrombosis.

If you're going to tell a patient the incidence of serious adverse reactions, then you have to tell him that a concerned medical decision was made to use a particular medication in his situation after careful consideration of the incidence of complications or side effects.

Emotionally unstable patients pose a special problem

There are patients who, because of severe emotional problems, could not handle the information contained in a patient package insert. Yet if we are going to have a package insert at all, we just can't have two inserts. I think we might simply have to tell the families of these patients to remove the insert from the package.

Legal implications of the patient package insert

Just what effect would a pa-

tient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

How do we handle an insert for medication used for a placebo effect?

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

Preparation of the package insert

The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

Pharmaceutical Manufacturers Association 1155 Fifteenth Street, N.W. Washington, D.C. 20005



A Giant Step For Ohio Medicine

Ohio physicians can be proud that one of the most forceful and effective malpractice bills in the country is now law in their state. On July 25, Governor James A. Rhodes signed Amended Substitute H.B. 682, the omnibus medical malpractice bill.

"The enactment of this legislation is a gigantic and hugely successful step in the right direction. It is like a bright light at the end of a long, dark tunnel," said OSMA President Maurice F. Lieber, M.D. "The bill is not the final answer, nor is it a panacea. But I can assure you that it is a giant step forward in solving the malpractice crisis."

Speaking to a group of county medical society executives, James H. Sammons, M.D., AMA Executive Vice President, said that Ohio's malpractice bill is the best in the country to date.

In a special report to OSMA membership, Dr. Lieber expressed Ohio medicine's appreciation of the fact that "major efforts to emasculate the legislation were repulsed by the Ohio General Assembly."

Amended Substitute H.B. 682 provides a balance of medical, legal, and insurance reforms. One of the major provisions of the new law is the establishment of a Joint Underwriting Authority (JUA). The JUA will provide medical professional liability insurance to any physician or hospital entitled to such insurance but unable to find acceptable policies in the voluntary market through ordinary methods. Coverage issued by the JUA is claims-made.

This plan will require that all insurance companies authorized to issue liability policies in this state shall contribute to the plan and shall be assessed, if necessary, to compensate for any losses the plan might incur.

A stabilization reserve fund will be generated by an assessment of \$250 on any non-JUA participant or by a 100% surcharge (up to a maximum of \$5,000) for any physician purchasing policies through the JUA. This fund will be used as a "cushion" between the possible losses of the JUA and the exposure of the insurance carriers.

An additional provision calls for a \$1,000 assessment of every Ohio physician if the stabilization fund goes into the "red" \$1,000,000. This complex scheme was devised to use physician dollars before Ohio's casualty insurance companies sustain losses. If the stabilization fund

dollars are not used, they are to be returned to the physicians who were assessed.

This joint underwriting association shall operate until December 31, 1978.

The Joint Underwriting Association is known as the Ohio Medical Professional Liability Insurance Underwriting Association. Their offices are at 1880 East Dublin-Granville Road, Columbus, Ohio 43229, and their telephone number is (614) 891-5400. They also have a WATS Line, (800) 282-8817.

Your local insurance representative is receiving information regarding the processing of applications and is in a position to assist you in obtaining coverage. A binder premium of \$1,000 accompaned by an application and request for coverage will assure you of coverage for a sufficient period of time for the Joint Underwriting Association to prepare your policy. If you are without coverage presently, we suggest that you immediately contact your local insurance representative and ask him to obtain a binder coverage for you.

A variety of legal reforms were adopted in Amended Substitute H.B. 682. These reforms will produce the long-range benefits by curbing the rising trend of increasing malpractice suits and premium rates.

The legal reforms are:

Voluntary/Binding Arbitration

Makes a small change in the Ohio Arbitration statutes so that agreements may be made voluntarily by patients and doctors, prior to treatment, to provide for binding arbitration if a disagreement should arise. The current statute only provides for an agreement to go to binding arbitration in existing problem areas, and the new provision would permit binding arbitration for disputes that might arise after the signing of the document. The patient has the right to cancel voluntary/binding arbitration within 60 days of discharge.

Compulsory/Non-Binding Arbitration

Requires that all malpractice cases not subject to voluntary/binding arbitration must go to a non-binding arbitration panel, whose findings are admissible as evidence in case either party disagrees with the panel's decision and the suit goes to subsequent trial. This panel is to be made up of a representative of the plaintiff, a

representative of the defendant, and a third person, the chairman, selected by the Judge of the Court of Common Pleas hearing the case. A full jury trial will be held if either party disagrees with the decision of the arbitration panel and members of the arbitration panel may be required to testify in the trial.

Statute of Limitations

Adds a provision to Ohio's current statute of limitations language. Ohio's malpractice statute of limitations now states that the patient may sue a physician within one year from the time of the cessation of the physician/ patient relationship, or, in the case of a foreign object left in the patient after surgery, within one year from the time the foreign object is found or should have been found. Minors may now sue within one year of reaching majority (18), allowing up to 19 years for a suit on an alleged injury to a newborn.

The new language keeps the one-year provision described above, but states that in any event, the suit must be filed within four years from the date of the alleged incident (whether or not the "foreign object" is found and whether or not there has been a cessation of the physician/patient relationship) and states that any minor under age 10 shall have until his fourteenth birthday to file suit. After his tenth birthday he is treated as an adult

This language removes much of the "tail" which keeps insurance companies from being able to tell what kind of claims will be made in the future and should also reduce the dollars needed to set reserves in malpractice cases

Statute of Frauds

Changes the provisions of the Ohio Statute of Frauds to provide that no patient may sue a physician for any oral promise that might have been made regarding the patient's prognosis. Thus, in order to claim a breach of a contract to cure or to provide a specific result, the patient must produce a written document outlining the promise or agreement which the physician has allegedly failed to meet.

	AM. SUB. H.B. 682	INTRODUCED	4. SUB-COMM	н. сомміттеє	H. FLOOR	S. SUB-COMM	S. COMMITTEE	S. FLOOR	FINAL VERSION
This chart	DATE	4-15	6-6			7-10			
1000	JOINT UNDERWRITING AUTHORITY	Х	χ	χ	χ	Х	χ	Х	χ
ndicates the	STABILIZATION FUND		50%	50%	50%	100%	100%	100%	100°
ndicates the	COURT OF CLAIMS	χ	χ	Х	Х	χ			
	VOL/BINDING ARBITRATION	Х	χ	χ	χ	χ	Х	X	Х
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alpractice	PEER REVIEW LIAB PROTECTION	χ	χ	χ	χ	χ	. х	χ	χ
•	PEER REVIEW RECORDS PROTECTION	Х	χ	Х	Х	Х	X	Х	X
11.	PLAINTIFF RECORDS ADMISSIBLE	χ	Х	χ	χ	χ	χ	Х	χ
7.47	150 HOURS CME	χ	χ	Х	X	Х	χ	Х	χ
	CONSUMER ON STATE MED BOARD					χ	χ	X	χ
	18 REASONS FOR LICENSE REMOVAL	Х	χ	χ	χ	χ	χ	Х	Х
	TOTAL REVISION MED PRACT ACT	χ							
	"PATIENT'S BILL OF RIGHTS"						χ		
	MALPRACTICE STUDY COMMISSION							χ	X

A Giant Step/continued

Contingent Fees

Instructs and demands the Ohio Supreme Court to establish a contingent fee schedule for plaintiff's attorneys on or before January 2, 1976. This provision calls for a fee schedule with a maximum of 33½% and the percentage is to be adjusted downward as the amount of the settlement or verdict increases.

\$200,000 General Damages Limitation

Places a limit of \$200,000 on the amount a plaintiff may receive for pain and suffering in a malpractice case.

Liability Immunity for Peer Review

Limits the liability of members or employers of utilization review committees, tissue committees or peer review committees for actions taken in good faith as a member or employee of those committees. This section also adds language to permit any member or employee of a hospital board or committee to have this limitation on his potential liability.

Protection on Peer Review Records

Provdes that the findings and data of a utilization review committee, tissue committee or peer review committee may *not* be used against a physician or hospital in a civil case. The purpose of this section is to ensure the confidentiality of peer review mechanisms.

Plaintiff's Medical and Hospital Records Available

Amends the current Ohio Statute relating to the patient/physician relationship. Now when a patient brings a malpractice action against a physician or hospital, the patient automatically waives the patient/physician statute and all medical and hospital records will be as accessible to the defense attorney as they are now to the plaintiff's attorney.

Informed Consent

Specifies language for a legally valid informed consent form for use in any surgical or medical procedure. A consent form, specifically delineated within the law, may be used and requires the physician to outline with the patient most problems which might arise out of any procedure about to be undertaken.

The person making the consent acknowledges that such disclosure of information has been made and all questions asked about the procedure or procedures have been answered in a satisfactory manner.

Expert Testimony

Requires that anyone giving expert testimony in a malpractice case must be engaged at least 3/4 time in either the active, clinical practice of medicine or be on the faculty of an accredited medical school.

Collateral Source Rule

Provides that any award in a malpractice suit must be reduced by an amount equal to any proceeds the plaintiff his received from any governmental programs or non-insurance sources, (e.g. Medicare, Medicaid, Welfare, Workmen's Compensation, Unemployment Compensation, etc.).

Elimination of Dollar Reference in Ad Damnum Clause

Provides that the amount of damages sought by the plaintiff shall not be stated in the initial complaint although the party against whom the action is being sought may at any time request a statement setting forth the amount of damages requested. In any event, a statement of the requested damages must be filed by the plaintiff at least sixty days prior to the date set for trial.

Medical Board Authority

Gives the State Medical Board authority to revoke licenses or to refuse to register or reinstate licenses for a number of specific reasons. Under current Ohio law, the Board must prove that a person is guilty of "gross immorality, grossly unprofessional or dishonest conduct." Because this language is subjective and difficult to prove, many courts have reinstated licenses of physicians after the Board has gone through long but necessary procedures to have these licenses revoked. The new language is legally specific and should result in fewer court-reinstated licenses.

Consumer on State Medical Board

Requires the Governor to appoint a consumer to the State Medical Board as a full voting member (four-year term).

Continuing Medical Education

Requires each physician licensed by the State of Ohio (M.D. or D.O.) to have at least 150 hours of continuing medical education each three years for triennial re-registration. There is no provision for any additional testing or re-certification, only proof of participation in CME.

Amended Substitute HB 682 was successfully and actively supported by your Ohio State Medical Association as a member of a consortium including the Ohio Department of Insurance, Ohio Hospital Association, Ohio State Medical Association and representatives from various insurance carriers in the State of Ohio. Amended Substitute HB 682 is, and always has been, a proposal for the people and every citizen in the State of Ohio will benefit by its passage.

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Shaping A Medical Malpractice Bill

Six months of diligent work by physicians, OSMA staff and other interested parties preceded the passage of an omnibus malpractice bill in Ohio. Amended Substitute H.B. 682 went through countless debates, revisions, amendments and votes before it was signed by Governor Rhodes on July 25. Following is a chronological report of the bill's progress through the Ohio General Assembly.

Ohio Department of Insurance

In January of 1975, the OSMA asked Harry V. Jump, Director of the Ohio Department of Insurance, to study remedies for the malpractice crisis. As a result, various groups affected by the malpractice crisis held a meeting in March. Attending were representatives from OSMA, the insurance industry, the Ohio Hospital Association, the Ohio State Bar Association and other groups. Director Jump divided these representatives into a legal subcommittee and a medical subcommittee.

Meeting separately, the committees presented recommendations from which a rough malpractice bill was drafted. A final draft was then composed by representatives from OSMA, the insurance industry, and the Ohio Hospital Association.

This draft called for a Joint Underwriting Authority and a Court of Claims with binding and non-binding arbitration. It included expert testimony and collateral source rules, elimination of the dollar reference in the ad damnum clause, a new statute of frauds section and an informed consent form. The bill established a plaintiff attorney's contingent fee schedule and a variety of medical reforms including a total revision of the Medical

Practice Act. This version was introduced into the Ohio House of Representatives on April 15 as H.B. 682, the omnibus medical malpractice bill.

House Insurance Committee

The prime sponsor of H.B. 682 was Representative William Hinig (D-New Philadelphia), Chairman of the House Insurance, Utilities and Financial Institutions Committee. Hinig held one hearing on H.B. 682 and immediately placed it into subcommittee.

House Insurance Subcommittee

The subcommittee responsible for reviewing H.B. 682 was composed of: Hinig; Ronald Weyandt (D-Akron); Vernon Cook (D-Akron); Leonard Camera (D-Lorain); William Batchelder (R-Medina); Robert Netzley (R-Laura); and Michael Oxley (R-Findlay).

After spending much time and effort revising the bill, the subcommittee members reported a substitute bill on June 6. The subcommittee's version maintained the Joint Underwriting Authority (JUA) and added a Stabilization Reserve Fund to protect casualty writers from risk under the JUA. Subcommittee amendments added a \$200,000 limit on general damages and changed the informed consent form, making it more confusing to use. The total revision of the Medical Practice Act was deleted, but provisions calling for 17 better ways to remove the license of a physician were retained.

Full House Insurance Committee

The full committee heard testimony on the substitute bill produced by the subcommittee. On June 10, the full committee reported a slightly amended version of the bill. The main change concerned the informed consent form which became even more difficult for physicians to use. The amended substitute bill was scheduled for debate on the House floor one week later.

House Floor Debate

During the floor debate, opponents of H.B. 682 succeeded in removing many important provisions of the bill. Both the expert testimony and collateral source rules were lost. The contingent fee schedule was replaced with a provision requiring the Ohio Supreme Court to establish a contingent fee program. A provision allowing cross-examination of arbitration members was added. After a lengthy debate, the House passed Amended Substitute H.B. 682 on June 17 by a 91-3 majority.

Senate Insurance Committee

Amended Substitute H.B. 682 was assigned to the Senate Elections, Financial Institutions, and Insurance Committee. Senator Tony Hall (D-Dayton), Chairman of the Committee, held one hearing and placed the bill into subcommittee. The subcommittee consisted of: Senators Robert O'Shaughnessy (D-Columbus), Chairman; Charles Butts (D-Cleveland); and Max Dennis (R-Wilmington). After reviewing the bill for three weeks, the subcommittee reported a new version on July 10.

Subcomittee amendments established a new Stabilization Reserve Fund with a 100 percent assessment on

all physicians and hospitals who use the Joint Underwriting Authority. A \$250 surcharge was set for physicians who do not buy insurance through the fund. Expert testimony and collateral source rules were reestablished. A \$500,000 limit on overall damages was created. The informed consent form was improved and the contingent fee schedule (rather than a schedule established by the Supreme Court) was put back into the bill. The language of the statute of limitations was changed. Finally, the subcommittee required that a consumer member be added to the Ohio State Medical Board. The subcommittee's hill was sent to the full Senate Committee

Full Senate Committee

After meeting twice, the full committee reported a new version to the Senate floor on July 15. The committee removed the Court of Claims, and the expert testimony and collateral source rules. The \$500,000 limit on general damages was also dropped. The committee added a poorly drafted "patient's bill of rights" which was simply a list of new ways a patient could sue his physician. The committee's bill was sent to the Senate for debate.

Full Senate Debate

Within two days, the full Senate voted on its own version of Amended Substitute H.B. 682. Once again, the expert testimony and collateral source rules were returned to the bill. The "patient's bill of rights" was deleted and a malpractice study commission was formed.

Conference Committee

On July 22, the House received the Senate's version of the malpractice bill. Refusing to accept Senate amendments, the representatives demanded a conference committee to settle the disagreement. The conference committee spent two days drafting a final version of Amended Substitute H.B. 682, but made only two changes.

First, the contingent fee schedule adopted by the Senate was deleted. Instead, the Supreme Court was requested to establish a contingent fee schedule, as the House originally proposed. The Supreme Court's schedule could not allow contingency fees to exceed 331/3 percent of the award. The fees also had to be on a graduating basis with the attorney's fee reduced as the award increased. Secondly, the collateral source rule was modified because of extreme pressure from both the Bar Association and the United Auto Workers. The new rule reduces awards in a malpractice suit by an amount equal to any non-insurance proceed which the plaintiff might have received (welfare, medicare, workmen's compensation, etc.).

Refer to page 650 for a detailed description of Amended Substitute H.B. 682 as it emerged from the conference committee.

Governor's Office

Amended Substitute H.B. 682 became law in Ohio when Governor Rhodes signed the bill on July 25.

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Warnings: Patients with severe cardiac disease should be given this medication with caution. Fever and possibly heat stroke may occur due to anhidrosis.

Overdosage may cause a curare-like action, with loss of voluntary muscle control. For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted. Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthīne.

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Adverse Reactions: Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

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INDIAN REMEDIES

R. Gordon Moore

Any discussion of Indian remedies would be incomplete without reference to the culture under which they were administered. The American Indian lived under a social order knit together by primitive religious beliefs, but one in which the individual played a unique role.

The Red Man's philosophy perhaps is well expressed in the words of a chant used to introduce the National Geographic Society's book, "The World of the American Indian": "You see, I stand in good relation to the earth . . . to the gods . . . to all that is beautiful . . . You see, I am alive; I am alive."

Attitudes toward illness and healing were closely tied to their religious beliefs. The medicine man was both religious leader and healer. There is evidence that the medicine man was well aware of the whole-man concept of healing. In fact, a regimen for the sick might involve the whole family, or even the whole tribe.

Many ceremonials dealt with sickness and health. For example, the Iroquois had two kinds of traditional religious practice, one associated with the agricultural cycle and the other with the curing and prevention of disease.

Medicine societies were an integral part of the cultures of some nations, for example, the False Face Society of the Iroquois. Curing rites were all-important, especially among tribes in which foraging was dominant.

The green-corn ceremony was one of the high ritualistic points in many tribal customs. Part of the ceremony had to do with intercessions for the prevention of sickness and many tribal people fasted in preparation for this ceremonial.

Some tribal members, before taking part in the green-corn ceremony, purified themselves by draughts of "the black drink," an emetic that in early days was made from the leaves of a kind of holly (Ilex vomitoria). At one time, warriors held a similar cleansing ceremony before taking the warpath.

In many cultures, the medicine man or shaman wielded great influence through his communication with the spirits. Psychosomatic medicine, by whatever name, was his forte.

But the ritualistic approach to treatment was only part of the Indian healer's repertoire. The National Geographic Society states that "Treatment was by individual practitioners — herbalists who handled symptoms and medicine men who dealt with origins — and by the 'social' approach of medicine societies."

The late Professor August C. Mahr, Ohio State University authority on Indian culture, reported that two observers, John Heckewelder and Frances Densmore, drew sharp lines of distinction between the "jugglers" (a term used by both) and the honest practitioners. To quote Heckewelder, there are the "good and honest practitioners who are in the habit of curing and healing diseases and wounds by the simple application of natural remedies . . . their science is entirely founded on observations, experience and the well tried efficiency of remedies . . ."

The late Dr. Howard Dittrick credited Professor Benjamin S. Barton, of the College of Philadelphia, with having deep respect for Indian herbs. Professor Barton wrote that the Indians had discovered "properties of the most inestimable (value in) medicine with which we are acquainted."

At the proper season, Indians gathered special roots, leaves and barks, prepared them after the traditional manner, and stored them for subsequent use. Barton stated that many of their crude drugs (later refined) had been incorporated into early dispensatories. The National Geographic Society, with a Twentieth Century vantage point, states that nearly 200 herbs and roots used by Indians have gone into official compendiums.

Malaria Treated With Dogwood Bark

Many Ohio settlers claimed that the bark of the dogwood tree was just as effective in the treatment of intermittent fever (malaria) as was the more standard Peruvian bark. Ironically, Peruvian bark was an Indian remedy, borrowed from South America. Missionaries of the Sixteenth Century discovered the natives of Peru using the bark of the cinchona tree for medical purposes. The bark was quickly introduced into Europe and into North America.

Early records indicate that most frontier physicians stocked Peruvian bark, the raw material from which quinine was later isolated.

Intermittent fever, or malaria, was perhaps the most prevalent disease throughout frontier Ohio. With its annual recurrence, Peruvian bark was held virtually indispensable. Dr. John Elliot, a frontier Army surgeon, when he found 49 of his troops ill with intermittent fever, said

(continued on next page)

Indian Remedies / continued

in dispair that there was "not an ounce of the bark to combat it." He added, "I am persuaded that every man who composes the garrison can take a pound of the bark during the sickly season." Dr. Elliot was stationed at several Army outposts along the Ohio valley during the period around the 1790's.

Quinine was isolated from Peruvian bark about 1820 and within the decade was in general use in Ohio for the

treatment of malarial diseases.

The advocates of dogwood as a substitute for Peruvian bark were not without their argument. Cornus, or the root bark of the flowering dogwood, has held its own in medicine. It yields cornin and tannin. Current medical dictionaries refer to its use as an antiperiodic (i.e., preventing recurrence of symptoms as in malaria).

Willow bark, a popular Indian remedy used to reduce fever and for other purposes, contains salicin, now produced synthetically as salicylic acid as the effective

ingredient in aspirin.

"... The medicine man wielded great influence through his communication with the spirits. Psychosomatic medicine was his forte."

Since tobacco was known for its medicinal value since early Colonial times, pioneer Ohio physicians probably acquired their knowledge about it from the Eastern states. Early settlers found the Indians using tobacco for medicinal purposes as well as in their ceremonies, and for the satisfying effect it gives.

The established treatment for boils, bites or superficial wounds was a politice made from the roots of the tobacco plant. Meriwether Lewis, of the Lewis and Clark team, described a simplified way of preparing a concoction by soaking the dried roots in water. In addition to treatment of wounds, the mixture was used as an eye and mouthwash, Lewis reported.

Among its many applications, tobacco was used in the treatment of asthma. Throughout the years, tobacco (Nicotiana tabacum) has held a high place as one of the

Indians' major contributions to medicine.

Barton named several Indian remedies that have made their way into the compendium, among them Indian hemp (Apocynum cannabium), squaw root (caulophyllum), wahoo (euonymus), golden seal (hydrastis canadensis), Indian tobacco (not a real tobacco but a plant yielding lobelia), May apple (podophyllum), sassafras, blood root (sanguinaria), and slippery elm (ulmus).

White Settlers Used Indian Herbs

Otto Juettner, in his medical records of the Indian campaigns of Generals St. Clair and Harmar, named a number of herbs used by Indian medicine men and adopted by white settlers. Among them were ipecac, known as the Indian physic; scurvy grass root combined with columbo and Miami root for use as a tonic; black snakeroot, a blood purifer and remedy for snake bite and wounds from poisoned arrows; mountain mint, a diuretic; horse balm, a diaphoretic; white pine, a poltice for wounds; blueberry, an antispasmodic used early in labor; pond lilly root for the King's evil; and sage tea, a febrifuge.

Many plants were named according to their medicinal uses. For example, scurvy grass was so named because it was used in treatment of scurvy. It is closely related to the family Brassicaceae which includes cab-

bages, mustards, etc.

In the Midwest, remedies for rattlesnake bites were made from snakeroot (Aristolochia serpentaria) and the Lion's heart (prenanthese rubicunda). Tea made from the bark of the white ash was another remedy for rattlesnake bite. The use of ginseng, the "spurious Columbo," and peppermint was noted in parts of the Northwest Territory. Balsam and tallow were used in treatment of wounds. Green herbs, especially wild onions, were used in the treatment of scurvy.

Dr. Dittrick reported that early physicians found virtue in the Indian treatment of venereal disease with Xanthoxylum (from the prickly ash). A species of Croton was employed by some tribes for the same purpose. A decoction of Seneca snakeroot (Polygala senega) was used by Northern Indians for treatment of syphilis, as was lobelia. The Indians supplemented these remedies with wild cherry bark, the root of the May apple and other plants. Broad-leaved or mountain laurel (Kalmia latifolia) and sarsparilla were also used for treatment of syphilis.

Wild cherry bark, though not recommended as a cure for syphilis, is used extensively in medicine today as a soothing and flavoring agent. Sarsaparilla held its own for many years in the treatment of chronic rheumatism,

skin diseases and syphilis.

Such an eminent authority as Surgeon General Richard Allison considered spiked saw root (serrotuli spicati) highly useful in the treatment of venereal disease. Major Jonathan Hart was persuaded that the Indians of the Northwest Territory could not cure confirmed syphilis. Dr. Dittrick referred to Barton as reporting that one who knew well the Shawnees and Delawares believed that they could cure gonorrhea, but that they could not rely on their own remedies in treatment of syphilis.

Dr. Dittrick states: "In contrast with all this confusion over treatment, in 1782, medical officers in Lower Canada were using various forms of mercury, and the Government was issuing pamphlets outlining mecurial therapy." On the Lewis and Clark expedition (1803-1805), Indian remedies were used for treatment of syphilis in addition to mercurial therapy.

Dr. Dittrick reported that a Moravian missionary testified to the effectiveness of a medicine woman who brought relief to a very painful abscess of the finger by poulticing it with the root of the common blue violet. The missionary referred to worked among the Indians of the Tuscarawas valley during the 1770's.

In addition to oral administration, powdered roots were sometimes prescribed as snuff, or mixed with tobacco and red willow bark and smoked in a pipe. Slight incissions by sharp flint or glass were made in the skin and the powdered root applied over the abrasion. Similarly, an instrument pricked bear's gall and charcoal into the skin. Herbs and roots were often mixed with grease. Bear's grease and deer tallow were favorites.

For earache and ear infection, a green ash limb was heated on one end while the sap oozing from the other end was dropped into the ear. Cobwebs were used to control bleeding.

Reportedly the first medical book published west of the Alleghenies was published in Cincinnati in 1813 and appropriately called "The Indian Doctor's Dispensatory." It was written by Dr. Peter Smith, who called himself "the Indian doctor" in spite of the fact that he was well trained and well qualified as a physician in his time.

Smith admittedly obtained much of his information by talking to doctors and medicine men in his wanderings through Pennsylvania, the Southern states as far as Georgia and finally to Ohio. He specified, however, that he tested all of the remedies before advocating their use by others.

One of Smith's remedies was the use of a strong decoction of the tannin-bearing pig-nut hickory bark to stop bleeding, as well as the standard application of cold compresses and alum.

Smith described mouth-to-mouth resuscitation for drowning victims very much as it is used today. This writer did not find reference as to where he learned this procedure.

Indian practitioners were adept at use of the enema. A deer's bladder was fitted with a reed as the syringe and various decoctions of herbs were used for fills. The Indians were not ignorant of the need for clean instruments. Professor Mahr reported that the reed was burned after use. The enema also was used to force feed patients who were not capable of taking food by mouth.

Mud Bath and Sweat Ovens

The Indians applied hydrotherapy and heliotherapy. Mud baths were given for certain ailments. Smallpox patients were immersed in a pit filled with soft mud heated with stones.

Professor Mahr reported that the sweat oven was a fixture in virtually every Indian community from the Atlantic to the Pacific. Various types of huts were used, varying in size to accommodate one to a half dozen or more persons at a time. The women had their own sweat ovens. Hot stones were used for heat. If a steam bath was desired, water, either plain or medicated, was poured over the hot stones. In some instances, herbs and roots were placed on the hot stones to produce fumes. For treatment of rheumatism, the patient was usually wrapped in blankets. For certain kinds of headache, a blanket was draped over the patient's head to capture the vapors. The sweat oven was used for a variety of ailments, or even for "that tired feeling."

Bleeding was not confined to the white man's practice of medicine. It would seem that bloodletting was a universal practice of all New World aborigines, from the Aztecs to the North American Indians. The medicine men made incisions with a sharp fragment of flint or glass, sometimes attached to a short wooden handle.

The Red Man used horns for cupping. The horn

"... Nearly two hundred herbs and roots used by Indians have gone into official compendiums."

was first heated, applied and allowed to cool for the suction. Some horns were opened at both ends, indicating that the medicine man applied suction by mouth.

Some authorities claimed that the Indian medicine men bled only from the ailing part of the body, apparently on the assumption that the Indian had no knowledge of the circulatory system. Professor Mahr refutes this claim. He states that the incision for bleeding was usually made on the forearm or ankle. There were exceptions. For example, some practitioners made incisions on the temple to treat headache or inflamed eyes.

Dr. Dittrick reported that the Indians were adept in many forms of surgery. He quoted authorities who described certain surgical procedures. After politicing boils until they were ripe, the medicine man would lance them with a sharp flint. Other references indicate that sores and boils were politiced with a concoction made from the root of the tobacco plant, from flour of Indian corn, or from other substances.

Densmore reported that she knew a patient who, as a boy, had had both legs amputated below the knee. His feet had been frozen and were in a hopeless condition, the report said. The medicine man had used an ordinary knife for the amputation, following which dressings of powdered bark of the wild cherry (Prunus serotina) were

Indian Remedies / continued

applied dry and renewed twice daily or as often as they became damp.

In another case, the medicine man treated a gangrenous wound with the inner bark of the white pine (Pinus strobus), the wild plum (Prunus americana) and the wild cherry (Prunus serotina). A knife was used "not to remove but to loosen" the affected flesh which was taken out by the medicine he applied. The medicine man specified that the knife and all medication must be kept clean, especially from rust.

(Frances Densmore made an exhaustive study of early Indian lore, although her actual work among the Indians came at a much later period.)

Reeds were woven together and used for splints, and cedar or basswood was shaped into casts for extremities. Densmore reported that splints were made of birch bark, heated and bent into the desired shape, after which they were as rigid as plaster of Paris.

The inner bark of basswood or fibers of the long tendons of a deer were used for suturing incised wounds.

A deer bladder with an attached quill was used for irrigating wounds. A piece of slippery elm bark was introduced into some wounds for drainage. In case of an abscessed tooth, the gum was lanced with a splinter from a tree struck by lightning. In removing a tooth, it was first struck forcibly to loosen it, then a sinew fastened about it and the patient's head jerked backward.

Some Indian tribes reportedly used a horse for reducing dislocations of the hip. A horse was deprived of water for several days. The patient was placed astride the horse with his legs fastened much as a saddle would

be strapped on. The horse was then led to water and the resulting traction reportedly was sufficient to reduce some dislocations.

Here's one for the ladies. Bumblebees were dried and powdered, combined with a decoction of alder root (Alnus incana) as a remedy for women's diseases.

Professor Mahr reported that to all appearances obstetrics and gynecology among the Eastern forest Indians was practiced exclusively by women, many of whom became highly efficient and skilled in their work. He further reported that he had found no evidence of instruments used nor manipulation practiced by the obstetricians. Customs in regard to birth seemed to vary considerably from community to community. In some cultures, the woman went into the woods alone and returned after the baby was born. Under other cultures, the expectant mother remained in camp and was attended by obstetricians.

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Mr. Moore was the Executive Editor and Executive Business Manager of *The Ohio State Medical Journal* for 26 years prior to his retirement in October 1974.

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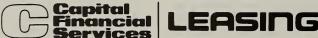
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proceedings of the council

Councilor Reports

The Councilors reported on various activities in their respective districts. This report included grievances and malpractice reports.

Federal Legislation

Mr. Edgar reported that the U.S. House of Representatives had deleted from H.R. 5546, the Medical Manpower Act of 1975, a provision that would have given the Secretary of Health, Education and Welfare total control over residency training programs. He reported that the provision in the bill that would require medical students to repay, by money or by service, on a pro-rated basis the federal funds given his medical school, had been amended to provide that pay-back would start two years, rather than immediately, after he begins practice.

Mr. Edgar also reported that a one-day hearing on H.R. 7847 — legislation designed to guarantee the success of HMO's by sharply reducing the required number of service HMO's must provide to receive federal funds, had been set for July 15, and that the American Medical

Association would testify regarding the bill.

Mr. Page reported on a number of legal actions being prosecuted by the American Medical Association.

State Legislation

Mr. Rader discussed a number of bills currently before the Ohio Legislature. The Council considered the measures and acted upon them as follows:

S.B. 201, to place a podiatrist on the Medical Board

opposed in principle.

H.B. 775, to separate health and physical education

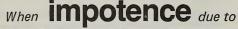
H.B. 908, to authorize state and local participation in National Health Planning and Resources Development Act of 1974—support.

H.B. 909, to license health care facilities—support.

Mr. Rader reviewed the current status of Sub. H.B. 682, the malpractice reform bill.

Constitution and Bylaws

Amendments to the Constitution and Bylaws of the following county medical societies were approved as submitted: Montgomery County Medical Society; Summit County Medical Society; Erie County Medical Society; Richland County Medical Society; Champaign County Medical Society; Van Wert County Medical Society, and the Academy of Medicine of Cincinnati.





DESCRIPTION: Methyltestosterone is 178-Hydroxy-17-Methylandrost-4-en-3-one. ACTIONS: Methyltestosterone is an oil soluble androgenic hormone. INDICATIONS: In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency, 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. PRECAUTIONS: Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. CONTRAINDICATIONS: Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. WARNINGS: If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. ADVERSE REACTIONS: Cholestatic jaundice • Oligospermia and decrease in ejaculatory volume and water retention • Priapism • Virilization in female patients • Hypersensitivity

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(continued from page 613)

Field Service

A report with regard to the activities of the Field Service Department was presented by Mr. Holcomb and was accepted.

Citizenship Matter

A question with regard to the requirements of citizenship or for the filing of a declaration of intent as a prerequisite to membership in the Ohio State Medical Association was referred to legal counsel for study.

Committee Appointment

Dr. J. Hutchison Williams was added to the OSMA Advisory Committee to the Ohio State Society of Medical Assistants by Dr. Lieber. The appointment was confirmed.

License Renewal Notices

The problem of providing notices to physicians with regard to renewal dates on medical licensing was discussed. Address changes make the delivery of renewal notices to many physicians extremely difficult. The Council requested that staff explore the development of a notification service for members similar to that used by other associations.

Change in Titles

The Council approved a request for the change in title of the Ohio Society of Ear, Nose and Throat to the Ohio Society of Otolaryngology. In addition, the Council approved change of designation of the Section of Ear, Nose and Throat to the Section of Otolaryngology.

Malpractice and Accident Prevention Program

The Council studied a document from the Ohio Hospital Association with regard to an Ohio Hospital Malpractice and Accident Prevention Program. The program received the endorsement of the Council.

Fall Council Meetings

The President announced September 20-21 and November 8-9, 1975, for the Fall meetings of the Council.

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Executive Director

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ACTION AND USES — DOSAGE: 1 tablet after breakfast and supper, or as required. In females, 3-week courses of therapy are recommended followed by a 1-week rest period. Withdrawal bleeding may occur during the rest period. PRECAUTIONS: Administer cautiously to female patients who tend to develop excessive hair growth or other signs of masculinization. CONTRAINDICATIONS: Patients in whom estrogen or androgen therapy should not be used, as in carcinoma of the breast, genital tract, or prostate, and in patients with a familial tendency to these types of malignancy. AVAILABLE: Bottles of 100 and 500 tablets. Rx only.

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Following are names of new members of the Ohio State Medical Association certified to the headquarters office during July 1975. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

Ashland (Ashland)

A Dakshinamurthi

K. Krishnamurthi

Butler (Hamilton)
Kenneth L. Wehr

Clermont (Batavia)
John A. Parlin

Clinton (Wilmington)
H. Chung Tai Hu
P. R. Lakhani
Wayne A. Lippert

Cuyahoga (Cleveland)
Victor M. Goldberg
T. B. Stefansson

Erie (Sandusky) Douglas C. Rist

Franklin (Columbus except
where noted)
Seong H. Hahn
Michael J. Harkins
Lawrence P. Heiny
Larry C. Carey
Janet A. Freno
Robert J. Keck, Westerville
Jae D. Lee, Worthington
Michael S. Lehv
Ann M. Rogers
Mervyn J. Samuel
George M. Shadle

Hamilton (Cincinnati)
Mark D. Hopping

Lucas

Roger Allen Miller, Toledo Hector R. Ramirez, Maumee

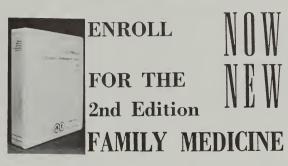
Mahoning (Youngstown)
William L. Crawford
Anthony M. Marinelli, Jr.
Alam M. Oadri

Portage (Garrettsville) Sang M. Leu

Summit (Akron except where noted) P. J. Agarwal, Cuyahoga Falls Thomas F. Bear, Cuvahoga Falls Fabian L. Breaux Stephen R. Burton Stephen L. Hershey Vincent H. Johnson, Jr. John R. Karlen Robert L. Klein Ramon L. Navarro Vincent Petno Timothy B. Rice Antonio A. Romero, Cuyahoga Falls Raphael E. Sayegh Richard S. Skoblar David M. Sokol Bipin B. Verma, Stow

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MRS. S. L. MELTZER, Communications Chairman

The new tabloid newspaper "Your Doctor Reports" made its debut in June in the waiting rooms of Ohio's physicians. It is a new and vital concept in public relations. Published by OSMA, it is an excellent monthly publication offering patients a variety of health and allied information for themselves and their families and alerting them to the hazards and advantages of present and proposed legislative programs. It is intensive public information at its best. I can think of no more important piece of reading material to be found in a doctor's waiting room.

One news item may discuss the importance of immunization against infectious disease while another warns against summer health dangers such as heat stroke, poison ivy and sunburn. Still another item alerts the public to a bill in the Ohio General Assembly or the United States Congress that personally involves the patient and his relationship with his physician.

Why am I using this column on auxiliary to herald a new OSMA publication? Because it is the best thing in communications I have seen in a long time and because I want to alert every county auxiliary and every doctor's wife in Ohio (and every doctor!) so that no waiting room will be without it! There's a powerful lot of material pouring into a doctor's office every day and I want to be sure that auxilians make sure "Your Doctor Reports" gets top priority! In other words, it's much too important to get overlooked.

Our OSMA auxiliary will be contributing material on a bimonthly basis that describes the outstanding community activities in which county auxiliaries engage. This should be an "eyeopener" for many who labor under the delusion that doctors' wives are only interested in social activities. The first such item appeared in the August issue on AMA-ERF and the \$1,361,546.21 check the national auxiliary turned over in June to AMA-ERF. (Ohio contributed \$76,519.78 to that overall amount.)

That Bus Driver Story

You may recall that in writing up the auxiliary's state convention in May, I mentioned an experience described by Mrs. Howard Liljestrand, the 1974-75 national auxiliary president at that convention. But I could only mention it because of space limitations and I promised to give something on it a little later on. Well, this is the "little later on."

Let me set the scene: it's the State of Missouri; a bus rumbling a considerable distance across it; a garrulous, know-it-all driver; and Betty Liljestrand seated just behind said driver. Mrs. Liljestrand is from Honolulu and en route to a visit with a sister who lives in Missouri. Mr. Driver is in an expansive mood and he starts talking to Betty, and at first it's just chit-chat. But then he warms up to tackle the problems in this country and he gets on to the subject of comparative incomes and rising costs of living.

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Can vou guess what happened next? He took off after the doctors. "Their prices are going up so fast, you just can't keep up with them." Then he stated that plumbers and electricians should be paid the same amount as doctors. He added that plumbers and electricians spend several years in an apprentice training "just like a doctor." Comments Betty Liljestrand: "I suddenly realized that in his mind a four-year apprenticeship as a plumber is the equivalent of medical school. He was thinking in terms of the time spent in medical school compared to that apprenticeship — not the more like twelve years when you count internship and residency to say nothing of the brain work, the night work, the endless studying and the great expense. He didn't know that I had anything to do with medicine and I certainly didn't intend to tell him because I was curious about what he might say." Well, he said plenty!

"The people of this country don't trust doctors any more, just like me." He said it challengingly. It just so happened that Betty Liljestrand had been trying to read her magazine — PRISM — a socio-economic publication. And as he uttered his challenge, she had just been studying a graph entitled "Who Does The Public Trust?" The graph was made from polls taken in '66, '72 and '73, showing the percent of public confidence in major institutions in our country. Number One on that list -"most trusted among men is Medicine." You can be sure Betty let him have it - the full information, I mean! He wanted to know "whose poll — who publishes that magazine. " It was becoming obvious that the 1974-75 national auxiliary president could no longer hide her identity. "Wow! I sure picked the one to talk to." he commented. And then quickly added "it's true, isn't it, that the AMA has the biggest lobby of any group in Washington?" Betty answered him by saving she would tell him exactly how many men the AMA had in Washington, if he would tell her how many lobbyists his union has there. He didn't need to be coaxed — "five hundred" he said proudly. Whereupon she explained that the AMA office in Washington consists of five men - lobbyists if you will — but that their biggest job is to check the approximately 2,800 bills on health introduced at each session of Congress, to be sure that these bills are in the best interests of providing good safe medicine to the people of this country. "I also told him that the budget for this office of five men is less than one per cent of the overall AMA budget," said Mrs. Liljestrand. His answer? "You must be lying I've been hearing for years that the AMA has the biggest lobby in Washington." There were other gripes and criticisms of the medical profession. He was a hard man to convince when it came to presenting medicine's side! "It made me think," she commented, "about how complex socio-economic aspects of medicine have become - how the general public misunderstands these problems — what this bodes for the future of our husbands, their patients and all of us."

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obituaries

Peter Z. Arapakis, M.D., Akron; University of Cincinnati College of Medicine, 1929; age 76; died July 3; member of OSMA and AMA.

Rolland D. Bateman, M.D., Zanesville; Ohio State University College of Medicine, 1924; age 78; died July

22; member of OSMA and AMA.

Richard Lewis Counts, M.D., Chillicothe; Jefferson Medical College of Philadelphia, 1936; age 65; died June, 24; member of OSMA and AMA.

Darrell Baker Faust, M.D., Plymouth; Ohio State University College of Medicine, 1935; age 70; died July

7; member of OSMA and AMA.

Irmgard Gebauer, M.D., Wilmington; University of Wurzburg, Germany, 1937; age 62; died July 12; member of OSMA and AMA.

Max Haas, M.D., Massillon; University of Cincinnati College of Medicine, 1941; age 59; died June 29; member of OSMA and AMA.

Hyman Helfman, M.D., Middletown; University of Cincinnati College of Medicine, 1932; age 68; died June 28; member of OSMA and AMA.

Louis Frederick Mutschmann, M.D., Alliance; Washington University School of Medicine, 1912; age 87; died July 17; member of OSMA and AMA.

Ernest Charles Orosz, M.D., St. Petersburg, Florida; University of Budapest, Hungary, 1937; age 64; died July 7; former member of OSMA and AMA.

Richard John Weiskittel, M.D., Cincinnati; University of Cincinnati College of Medicine, 1931; age 72; died July 6; member of OSMA and AMA.

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VOL. 71

OCTOBER, 1975



Clinical and Scientific Articles

SUBACUTE SCLEROSING PANENCEPHALITIS George W. Paulson, M.D., Columbus	695
THE SELECTION OF ADRENOCORTICOSTEROID PREPARATIONS Kenneth Kreines, M.D., and Irwin C. Weinberg, Cincinnati	698
BIOPSY-CONFIRMED SARCOID INTERSTITIAL FIBROSIS AFTER A 15-YEAR REMISSION Mark R. Schuyler, M.D.; Dennis E. Niewoehner, M.D.; and Jerome I. Kleinerman, M.D., Cleveland	707
A GENERALIST'S APPROACH TO DIAGNOSTIC CHEST X-RAY Henry Bachman, M.D., McConnelsville	708
Special Articles	
THE 111TH OHIO GENERAL ASSEMBLY A REPORT FROM THE OSMA STATE LEGISLATION DEPARTMENT	719
COLONIAL MEDICINE IN CINCINNATI Arthur G. King, M.D.	722
EVALUATE YOUR MEDICAL PRACTICE	

Features

WITH A PATIENT OPINION POLL

I Curar os			
News	684	Continuing Education	732
Comments	717	Obituaries	745
Ohio Health News	711	Journal Advertisers	746
New Members	731	Classified Ads	747
Woman's Auxiliary	738		

Cover: October is the third annual Immunization Action Month. This photograph of a sculpture representing Dr. Edward Jenner (1749-1823) giving the "First Vaccination — Immunization" was provided by Merck, Sharp & Dohme, Div. of Merck & Co., Inc. See page 686 for further details of Immunization Action Month.

726

Ohio Health Service Areas Approved by Federal Gov't.

The federal government has notified Governor Rhodes that it has decided to accept Ohio's proposal for dividing the state into health service areas with only minor changes.

Earlier this year, Ohio Health Director John H. Ackerman, M.D., held public hearings on proposed health service areas as required by a recent federal law. Following testimony by various health care organizations and citizens, Dr. Ackerman recommended to the Governor that the state be divided into ten areas.

Governor Rhodes endorsed the recommendations and forwarded them to the U.S. Department of Health, Education and Welfare with a request that a special exception be made for the area centered around Allen County, which does not meet minimum population requirements called for in the federal law. The initial federal review refused to allow the exception, but the Governor re-submitted the Ohio plan with an explanation that the Greater Ottawa Valley region around Allen County was a viable and sufficient health service area.

The Secretary of HEW has notified Governor Rhodes that the original Ohio plan, with the exception of some Kentucky border counties, has been accepted.

Refer to page 413 of the June, 1975 issue of The Journal for a description of these health service areas.

Ohio Doctor Is Candidate For AMA President-Elect

OSMA has announced its support of the candidacy of John H. Budd, M.D., for the office of President-Elect of the American Medical Association. The election will be held at AMA's 1976 Annual Convention in Dallas, Texas. He is a family physician in private practice in Cleveland.

Dr. Budd has been a Trustee of the American Medical Association since 1970. He currently serves as Secretary of the Board of Trustees and, concurrently, as Secretary-Treasurer of the American Medical Association. He has an abiding concern for and an excellent understanding of the affairs of the AMA.

In addition, Dr. Budd is the Vice President of the American Medical Association Education and Research Foundation (AMA-ERF), a Board representative to the National Association of Blue Shield Plans, an AMA Commissioner on the Joint Commission on Accreditation of Hospitals, and a member of the Medical Liability Commission.



John H. Budd, M.D.

From each of these positions, Dr. Budd has achieved great comprehension of the needs and functions of the AMA and its role in representing the nation's physicians. He will serve America's physicians ably with these attributes.

Serving on Dr. Budd's campaign committee are: Drs. Oscar W. Clarke; W. J. Lewis; Dwight L. Becker; P. John Robechek; and B. Leslie Huffman, Jr.

HEW Withdraws UR Regs; AMA Drops Its Lawsuit

The AMA dropped its lawsuit against the Department of HEW when F. David Mathews, Secretary of HEW, decided that utilization review regulations governing hospital admissions of Medicare and Medicaid patients should be changed.

The regulations, which will now be withdrawn, required that a hospital committee review the admission of all Medicare and Medicaid patients within one working day of admission to determine whether the admission was "medically necessary," according to pre-established written criteria and norms.

In a lawsuit filed on February 20, 1975, the AMA

contended that these regulations constituted an unlawful interference with the rights of patients and physicians. Throughout the lawsuit, the AMA has maintained that the medical necessity of hospitalization could not be determined within one working day of admission. The AMA further contended that this decision could best be made, not by a committee examining medical records against pre-existing criteria, but by the attending physician most familiar with the personal circumstances of the patient. The AMA also believes that special provision should be made for the problems of small and rural hospitals.

As a result of the AMA's lawsuit, Judge Julius J. Hoffman of the U.S. District Court for the Northern District of Illinois, issued a preliminary injunction against the challenged regulations on May 27. The preliminary injunction was affirmed by the U.S. Court of Appeals for the Seventh Circuit on July 22.

The Secretary of HEW has now signed a notice, to be published in the Federal Register, that he will withdraw the enjoined regulations and certain related provisions. He will propose new language to replace the regulations. According to a stipulation filed with the Court, the AMA has dismissed its suit without prejudice, meaning that it can be refiled at a later date if deemed necessary.

During Its First Month, JUA Gets 823 Applications

In order to keep OSMA members informed, each upcoming issue of The Journal will contain a progress report on the Joint Underwriting Association (JUA). Authorized by the recently enacted omnibus medical malpractice bill, H.B. 682, the JUA makes professional liability insurance available to physicians, surgeons, and hospitals. The JUA is officially known as the Ohio Medical Professional Liability Underwriting Association.

The JUA's first full month of operation produced 823 applications, a larger number than had been expected. On 528 of the applications, coverage as requested has been effected. The JUA office is notifying the remaining applicants of their premiums through quotation letters. To effect coverage, the premium or provisional binder premium must have been received at the JUA office in Columbus.

The Stabilization Reserve Fund (SRF), created by

H.B. 682, has also become a reality. All licensed physicians insuring through the JUA will have to pay up to 100 percent of the premium with a maximum of \$5,000 into the SRF. All licensed physicians renewing their professional liability coverage in the private insurance market will also contribute to the SRF through an annual charge of \$250.00. Beginning next month, The Journal will publish the SRF payments made to date by all physicians, surgeons, and hospitals.

The JUA office personnel have advised The Journal that their phones are extremely busy. Therefore, anyone who wishes to receive a premium quotation, is asked to send an application to the JUA office four to six weeks prior to the expiration of present coverage. Aetna Life and Casualty does not intend to renew any doctors after December 1, 1975. (If Aetna is your present carrier, you should contact your agent and take the necessary action.)

The Journal will also advise OSMA members of loss figures and premium figures, and other pertinent statistics.

OSMA's Executive Director Elected To ASAE Board

Hart F. Page, OSMA's Executive Director, was recently elected to the Board of Directors of the American Society of Association Executives (ASAE). He was among eight newly-elected ASAE directors introduced to members at the society's first European convention in Paris.

Page was elected by mail ballot to serve a threeyear term on the ASAE policy-making board. A past president of the ASAE-affiliated Ohio Trade Association Executives, Page has served for many years as an active member or officer of several other professional societies on the national, state, and local levels.

As the so-called "association of associations," ASAE's more than 5,300 members manage the leading business, professional, educational, technical, and industrial associations in the United States and Canada. This membership, in turn, represents an underlying constituency estimated at more than 22 million persons and firms belonging to national, regional, state, and local associations.

(More News on next page)



Akron Doctor Publishes Book On "Practical Psychiatry"

"If I were ever to teach a course and could not find a satisfactory text, I would write one," James R. Hodge, M.D. of Akron once remarked. Now he has done just that. Practical Psychiatry for the Primary Physician has been published by the Nelson-Hall Publishing Company of Chicago.

Drawing from his experiences in teaching, supervising, evaluating, and consulting in continuing education, Dr. Hodges has produced a reference guide for the nonpsychiatrically trained physician.

Primary physicians are often called upon to treat not only physical problems but also the emotional and mental problems of their patients. The book is directed to the informational needs of the physician who is not primarily interested in psychiatric theory but in learning how to handle the psychiatric aspects of his or her medical practice. The basic concepts of psychiatric treatment are offered in simple terms for use in the everyday practice of medicine.

Dr. Hodge is Head of Psychiatry at Akron City Hospital; Adjunct Professor of Psychology at Akron University; and a Consultant to the Ohio Academy of Family Physicians Continuing Education in Psychiatry Project. He is also a member of the American Psychiatric Association's Subcommittee on the Continuing Education of Physicians, and of the American College of Psychiatrists. He is in full-time private practice in Akron.

Have Your Preschool Patients Been Properly Immunized?

October is the third annual Immunization Action Month. Both the OSMA and AMA will join other medical organizations in acting to increase immunity levels among preschool children. The federal government will also participate through the U.S. Center for Disease Control.

Although the percentage of unprotected preschoolers has declined since the Immunization Action Month program started in 1973, some five million 1-to-4 year-olds are still immunized inadequately or not at all. Children still die from disease for which safe, effective vaccines exist. The immunity level is such that epidemics of polio,

measles, German measles and other communicable disease could occur.

"The problem," says Maurice F. Lieber, M.D., OSMA President, "is that people no longer fear such disease since vaccines can now prevent it. Therefore, parents become lax about having their children vaccinated. As a result, many children remain needlessly and dangerously vulnerable to serious disease, disability, and even death."

During October, OSMA's Media Relations Department will send news releases to newspapers throughout Ohio, urging parents to get their children properly immunized. Public service announcements will also be furnished to radio and television stations. Members of the Auxiliary to OSMA will distribute pamphlets to physicians' offices.

OSU's University Hospitals To Build 9-Story Patient Tower

Ohio State University will receive a state appropriation of \$28 million for completion of the Clinical Medical Sciences Education Facility in the university's medical center.

Funds for addition of a nine-story patient tower will come from the capital improvements bill signed on August 29 by Gov. James A. Rhodes.

The proposed 362-bed tower will be the second phase of construction of what will be a 12-story facility. The tower will be built over a three-story project currently under construction. Completion of the entire structure will increase patient capacity at the University Hospitals to 1,142.

The first phase of construction includes new facilities for an Emergency Department, Pharmacy Department, clinical classrooms and seminar rooms, a radiology area and clinical laboratories. The second part will include additional patient rooms and expanded classroom facilities for Ohio State students in medicine, nursing and the allied medical professions.

The Clinical Medical Sciences Education Facility, located southwest of the main entrance to University Hospital, will connect to the main hospital via elevated corridors.

Completion date has not yet been set for the project. Construction will not interrupt the normal operation of the University Hospitals.

(More News on page 692)

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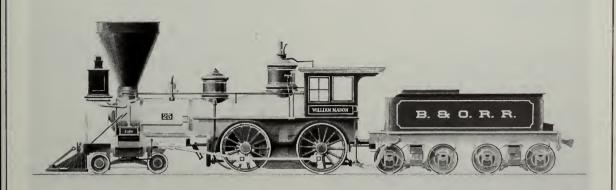
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For many years Robins has spotlighted the expectorant action of the Robitussin cough formulations by featuring action photographs of steam engines. In keeping with this tradition, the company recently commissioned a well-known illustrator to render full-color drawings of several classic locomotives... accurate to the minutest detail. The first of the series is now available. To order your print suitable for framing, write "Robitussin Clear-Tract Engine #1" on your Rx pad and mail to "Vintage Locomotives," Dept. T4, A. H. Robins Company, 1407 Cummings Drive, Richmond, Va. 23220.



The William Mason (1856)

Welfare Dept. Completes Survey on EPSDT Program

The Department of Public Welfare has recently completed an extensive survey of the Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program in the State of Ohio. This preventive health program for Medicaid-eligible children is now being administered in every county in the state. Some counties report that nearly all eligible children have received an initial comprehensive examination under the EPSDT Program.

The survey reflects that EPSDT services are currently being provided by individual physicians, group practitioners, free-standing private and public health clinics, and hospital out-patient clinics. Over 1,100 individual physicians are participating in the examination, diagnostic and/or treatment phases of the program. Most counties report a steady increase in the number of physicians participating in the past year, although a substantial number indicate that there remains an insufficient number of participating physicians to fully implement the EPSDT Program.

The Department has created a Bureau of EPSDT to consolidate administrative structure and support for this priority program. The Bureau, which conducted the state-wide survey, is available to answer any inquiries from physicians interested in any aspect of the program. Please address inquiries to:

(Mrs.) Loyce C. Scott, ACSW Chief, Bureau of EPSDT State Office Tower - 34th Floor 30 East Broad Street Columbus, Ohio 43215

AMA Clinical Convention To Stress Continuing Education

Continuing education for physicians will be the theme of the 28th Clinical Convention of the American Medical Association November 30-December 5 in Honolulu.

Forty-one post-graduate courses will be offered to physicians attending the convention. Subjects will cover the entire range of medical practice—dermatology, blood lipids, infectious diseases in children, new antibiotics, family planning, sexual difficulties, management of critically ill patients, special medical problems of women,

child abuse, allergies, emergency room X-rays, resuscitation in heart attacks.

Physicians involved in sports medicine will take courses on the physical exam, medical problems of karate, judo and yoga, emergency care on the field, wrestling, swimming and diving, and rehabilitation of the injured athlete.

Luncheon round tables will include sessions on ancient Polynesian medicine and on travel health.

Special lectures will be presented on the latest information on the state of the art in treatment of high blood lipids, stress ulcers, breast cancer, poisons, antibiotic therapy, coronary artery surgery, stomach cancer, computerized scanning, management of obesity and pulmonary clots.

General sessions will be presented on human sexuality, office management of alcoholism, and on weight control, diet and physical fitness.

Registration for the convention will open on Saturday, November 29. Courses and lectures will be held

December 1-December 5.

The AMA's policy-making body, the House of Delegates, will hold its semi-annual meeting November 30-December 3.

Further information on the convention is available from the Department of Scientific Assembly, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

It's Not Too Early For Influenza Vaccinations

Anyone planning to travel this winter to the East or West Coast, or areas outside the United States, should receive an influenza vaccine during September or October, recommends the Director of Infectious Diseases Services at The Ohio State University.

All Americans in the high risk group should be inoculated by mid-November, further advises the U.S. Public Health Service Advisory Committee on Immunization Practices. The high risk group, as defined by the Public Health Services, includes:

• The chronically ill—heart disease, bronchopulmonary problems, renal difficulties, diabetes mellitus, and other metabolic disorders.

• People 65 years of age and older.

Only one of every ten Americans in the high risk group is being vaccinated each year against influenza.

Ohio Family Physicians Elect New Officers

Alford C. Diller, M.D., Convoy, was installed as the 28th President of the Ohio Academy of Family Physicians. He succeeds Carl E. Spragg, M.D. of New Concord

The statewide 1,900-member family physician organization held its annual scientific assembly at the Sheraton-Columbus Hotel on August 1-3. Governor James A. Rhodes proclaimed it Family Physician Week.

Other newly installed officers are: Doctors H. Judson Reamy of Dover as President Elect; Glen F. Aukerman of Jackson as Vice President; A. S. Ahbel of Canton as Speaker of House; Rocco M. Antennucci of Mogadore as Vice Speaker; Robert S. Young of Johnstown as national delegate; and H. Judson Reamy of Dover as national alternate.

Newly elected directors are: Doctors Jerome N. Janson of Cincinnati; George H. McIlroy of Celina; Melvin L. Eckhouse of Maple Hts; N. D. Lavapies, Tiltonsville; Lewis Coppel of Chillicothe; John Robinson of Wooster, and Harold E. Grover of Wadsworth.

During the Annual Banquet, Doctor Robert S. Young of Youngstown, was selected as the Family Physician of the Year for dedication and service to his community and his diligent pursuit of family practice principles. John W. Heffelfinger, M.D., Columbus, was honored for his outstanding postgraduate record.

Eleven members, each with fifty years in medicine, were also honored: James H. Arnold, M.D., Lebanon; David Danenberg, M.D., St. Clairsville; Joseph D. Hayden, M.D., Akron; Clifford L. Keidel, M.D., Cleves; Hyman P. Levin, M.D., Cleveland; Salvatore Luca, M.D., Marblehead; Rolland L. Mansell, M.D., Medina; William A. Reed, M.D., Burton; E. Paul Shepard, M.D., Columbus; Chester P. Swett, M.D., Lancaster; and Ernest R. Valentine, M.D., Alliance.

AMA To Develop Medical Care Programs for Jail Inmates

Medium-sentence jails are frequently unable to provide adequate health care to their inmates, disclosed a survey by the AMA in 1972. The AMA has now accepted

a grant from a branch of the U.S. Department of Justice to organize model projects to improve prison health care in six states. According to James H. Sammons, M.D., Executive Vice President, "The pilot program will point the way for a long term effort to upgrade the health care of inmates in correctional institutions—an area sorely neglected by society in the past."

Medical care guidelines will be developed from the program which can be implemented in all 50 states. Eventually, it is expected that health care facilities and programs in jails will be certified, similar to accreditation programs for hospitals and medical schools.

The program will run for at least two years, with expenses underwritten by \$448,000 a year in grant funds from the federal Law Enforcement Assistance Administration. The AMA will contribute additional funds.

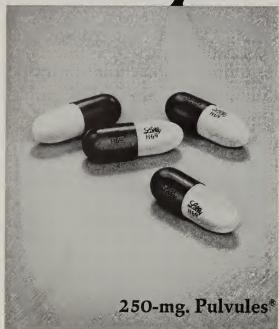
The six states that will participate in the model projects will be announced later. At the beginning of the pilot program, state and local medical societies will survey the jails in their areas to determine the adequacy of health care now being provided to inmates. Based on their surveys, programs will be developed according to the jails' specific needs. Various ways of delivering health care will be explored, such as visiting or on-call physicians, participation of medical school faculty and/or hospital staff, and use of medical assistants and paramedical personnel.

The pilot projects will be limited to correctional facilities where prisoners are held for medium-length sentences. Neither long-term prisons, such as state prisons, nor short-term jails, such as overnight "lockups," will be included.

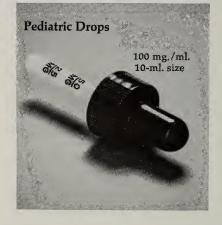
If successful, the pilot project will be extended to a national program for certification of jails as to their medical care and health services, including the adequacy of the facilities.

Refer to The Journal's August issue (page 565) for an analysis of the health care Ohio inmates receive, as reported by OSMA's Committee on Medical Care in Prisons and Jails. The Committee found that health care in Ohio jails and prisons is geared mainly toward dealing with problems only after they have occurred. Almost no attention is paid to preventive medicine, and special facilities are rarely provided for treating alcoholism, mental illness, and drug abuse.

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Subacute Sclerosing Panencephalitis

George W. Paulson, M.D.

Subacute sclerosing panecephalitis (SSPE) is a slowly progressive viral infection of the nervous system which appears due to the measles virus. The disease can present as psychiatric disorders, usually in a teenager, and in later stages, patients develop myoclonic twitches or even seizure phenomena. The diagnosis can be made by cerebrospinal fluid (CSF) examination (measles titre) and can be suspected on the basis of the electroencephalogram (EEG). Several representative cases of this occasional diagnostic puzzle are presented.

THIS PRIVATE NEUROLOGIC office has evaluated eight patients with subacute sclerosing panencephalitis (SSPE) in the past seven years, and two such cases are summarized below. This condition should be known by physicians in Ohio because it appears to be relatively prevalent in the Ohio River Valley and can present a diagnostic problem for specialists in pediatrics, psychiatry, or family practice. SSPE is a subacute process which usually presents as a psychiatric illness and which has a course of from 6 to 18 months. During the decline of the patient, which consists of slow deterioration involving both psychic and physical aspects, the disease produces marked anguish both in the physician and in the families of those afflicted.¹

Disease Manifestation

An 18-year-old male developed decreasing school performance preliminarily attributed to drugs. Abrupt shifts in behavior with aggressive language and actions led to hospitalization in a psychiatric institute in Columbus. While there, he was discovered to have myoclonus and abnormal psychological tests, and an abnomal electroencephalogram (EEG) was recorded. (See illustration.) The EEG was consistent with the pattern seen in subacute sclerosing panencephalitis. In addition, measles antibody titres were elevated in the spinal fluid. He was eventually transferred to the National Institutes of Health in Washington, D.C. where the diagnosis was confirmed. The major physical abnormality during his illness was severe myoclonus which occurred at approximately ten times per minute. The deep tendon reflexes were hyperactive, but he had no other obvious abnormalities. He was discharged on carbamazepine and diphenylhydantoin therapy, having previously received diazepam. He was given a trial of transfer factor supplied through research laboratories of the National Institutes of Health, but neither this nor other approaches led to permanent improvement, although there was a transient stability in the clinical state.

A 17-year-old male was admitted for psychiatric problems and, while in the hospital, was discovered to have myoclonic twitching. The psychiatric changes had been present for about six months and were characterized by major deterioration in school performance and difficulty with interpersonal relationships. The fine myoclonic jerks, which were noticed initially, worsened at home after he was released. He finally became difficult for the mother to feed, and was readmitted a month later. On the second hospitalization, the neurologic examination revealed a decreased level of consciousness although he could still respond appropriately to questioning. At this time, his tendon reflexes were hyperactive with obvious and incessant myoclonic twitches observed at intervals of approximately four to ten seconds. The laboratory data was extensive, but was all entirely

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normal, with the exception of a rubeola titer in the cerebrospinal fluid (CSF) of 1:4, considered strongly suggestive of SSPE. Electroencephalogram revealed changes in the retina consistent with SSPE, including exudates and scattered depigmented areas. When seen approximately one year later, he had regressed to marked spasticity, but for approximately two months the disease had leveled out without apparent deterioration in his physical state and he appeared to be a little more responsive than he had been earlier.

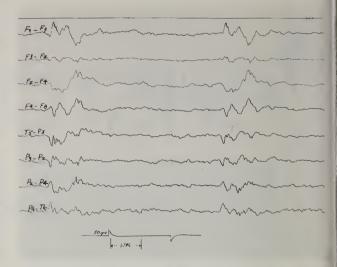
Clinical Aspects

The major clinical features of SSPE are seen in three phases although the characteristics of each period overlap. Most cases are aged 5 to 20 years, and the course is usually predictable. In phase one, the symptoms are primarily psychiatric. At this time, there may be intellectual and personality changes. The total school performance deteriorates, impulsivity becomes prominent, and the children may be accused of taking drugs or may be hospitalized for suspected psychosis. Specific IQ testing confirms a general decline in intellectual ability, and perceptive psychologic testing frequently documents organic disease. Near the end of the first period and extending through it and into the next period, the patient usually develops brief seizures or sudden myoclonic jerks, These myoclonic jerks are particularly characteristic of SSPE and appear abrupt and fleeting with a recurrence as often as every ten seconds. Some patients have a tendency to interrupt their conversation at the time of the brief myoclonic contractions, which involves one or both sides of the body. Occasionally, focal twitches of a hand or of the face are seen and, because of this or because a few patients develop generalized major convulsions, the question of cerebral neoplasm may arise. The myoclonic jerks often can be controlled with diazepam or phenobarbital, and the major seizures may be prevented by other anticonvulsants. Recognition of the gravity of the situation is almost always late and usually occurs during stage two.

In the third and final stage, the personality turmoil is replaced by diffuse dementia and the jerks may become less apparent as patients deteriorate. The patients finally become bedridden with contracted limbs, scattered twitches, and remain in a mute and unresponsive state. Death usually results from inanition, infection, decubiti, and other complications frequently noted in the end stages of chronic neurologic disease.

Diagnosis

Diagnosis of SSPE depends on the practitioner's recognition of the clinical state and once suspicions are raised, diagnosis can be confirmed by CSF examination and by EEG. The presence of detectable levels of measles antibody in the CSF, as well as abnormalities in platelet agglutination tests or in the gamma globulin fraction of the CSF can be strongly suggestive of SSPE. Such testing of the titre of measles antibody in CSF can now be performed through the Ohio Department of Health laboratories, or material can be sent directly to the Na-



EEG in case 1 illustrated high voltage repetitive discharges.

tional Institutes of Health in Washington. An additional—and at times equally diagnostic—feature of SSPE is the EEG. The EEGs of as many as two-thirds of the patients with SSPE will display high voltage bursts of slow waves and alternating sharp waves, often stereotyped and repetitive enough to be called "periodic." In later stages of the disease, the EEG discharges may be associated with a loss of normal background rhythms, or with spike or sharp wave discharges. At times, the periodicity is not immediately apparent or is so separated in time that this feature in the EEG is overlooked by an unsuspecting electroencephalographer.

Last, though usually not mandatory, diagnosis can be confirmed by brain biopsy. This was done in two patients seen by the author and, in these and in similar cases, viral inclusion bodies could be seen. Such inclusion bodies are best seen in the patients who are more severely affected and, in fact, these inclusion bodies represent the virus particles themselves. Biopsy usually is not required to make the diagnosis.

Pathogenesis

It is now recognized that this is a viral disease, one of the so-called "slow virus disorders" of the central nervous system. Measles encephalitis is usually a much more acute disorder and displays elements of both active viral infection and of an allergic response. In SSPE, the massive allergic reaction apparently is absent and the virus lodges in a subclinical state in many neuronal cells, slowly manifesting evidence of damage and eventual destruction of the cells. It is not that the virus is "slow"—only that the clinical features of the disorder are attenuated or prolonged. That such a smoldering infection of the CNS can occur is no surprise, but the importance of such subacute viral infection is now clear in some of the

presenile dementias and in several rare neurologic diseases.

Treatment

Transfer factors and other antimetabolic or antiinflammatory materials have been used for therapy, as in case number one, without reported success, X-ray therapy, administered as spray irradiation, has been tried. also without benefit. Massive amounts of medications such as vitamin C, reported to help some viral illnesses in animals, was also used without significant benefit in one of our cases. Amantadine hydrochloride, an antiviral agent used in parkinsonism, has also been tried by us and others, again without significant benefit. Sherrard has reported transitory improvement in one patient with SSPE who developed chicken pox, but efforts to reproduce this in others has not been successful. Symptomatic therapy does include the use of diazepam and other muscle relaxants since these will often lesson the myoclonic jerks. At times, tranquilizers or antidepressants may be necessary because of the emotional distress of the patient reported here, a chronic or smoldering form of the patient, or to soften the severe psychiatric manifestations of SSPE.

Prognosis

Many patients are dead within six months to two years after onset of illness. In a few cases, as in the second patient reported here, a chronic or smoldering form of the disorder can occur and last for several years more. Donner, el al² review two patients in whom there was apparent

partial remission after about two years of the illness. One patient who had improved had a relapse after eight years of remission and then seemed again to recover partially from the second exacerbation, though there was a residual severe mental defect. It seems possible, therefore, for this disease to reach a quiescent or recovery phase in rare individuals. Though the changes in the EEG and spinal fluid may disappear, the condition can recur and the prognosis, therefore, must always appear grim in regard to both the neurologic recovery and the possibility of life itself

Conclusion

This is a brief report of subacute sclerosing panencephalitis (SSPE). This progressive neurologic disease usually is found in late childhood and is due to an infection with the measles virus. Psychiatric deterioration, myoclonic jerks, and gradual physical decline are classic features of the disease. Diagnosis rests on clinical suspicion, presence of the typical EEG, and elevated levels of measles antibody in the CSF. There is no cure. The myoclonic jerks may be ameliorated, although only temporarily, by treatment with steroids or diazepam.

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The Selection of Adrenocorticosteroid Preparations

Kenneth Kreines, M.D. Irwin C. Weinberg

Faced with the need to make quick therapeutic decisions, the practicing physician can become bewildered by the scores of corticosteroid products that are available to him. The manufacturers invariably claim that their own products are superior to those of their competitors, but justification for these claims cannot always be found. Indeed, there is a definite lack of data derived from carefully controlled studies of efficacy in

The information contained in this report was gathered in an effort to list all of the available products and to discuss briefly such factors as relative potency, durations of action, and cost, an understanding of which is necessary for their selection.

SINCE 1939, when Pfiffner and Swingle first described the beneficial effects of treatment of adrenal insufficiency with adrenocortical extracts¹ and 1949, when Hench, et al first demonstrated the antirheumatic action of cortisone,² scores of steroid compounds either have been isolated or synthesized. Many of these have proved to be dramatically effective in a wide variety of clinical situations³⁻⁵ and, indeed, the availability of these "wonder drugs" is so taken for granted today that the practice of medicine without them seems inconceivable.

The modern clinician is confronted with a bewildering array of corticosteroid products. In 1973, there were more than a dozen compounds available in the free as well as in a variety of esterified forms, marketed under 39 brand names (plus many more marketed under generic name), all in a wide range of concentrations, tablet, ampule, and vial sizes. It is the present purpose to tabulate the available products and to discuss briefly certain of their characteristics such as relative potency and effi-

cacy, onset and duration of action, and cost, an appreciation of which is vital for their intelligent selection.

Relative Potency and Relative Efficacy

The relative anti-inflammatory and relative sodiumretaining potencies of the available corticosteroids are shown in Table 1.

Relative potency is usually estimated in rodents by measuring the effect of treatment on thymus involution, sodium retention ("mineralocorticoid action"), liver glycogen deposition ("glucocorticoid action"), suppression of granuloma formation about implanted asbestos or cotton particles ("anti-inflammatory action"), or, in humans, by measurements of the effect of treatment on suppression of circulating eosinophils or suppression of ACTH, the latter assessed indirectly through determination of plasma cortisol levels with or without the simultaneous administration of Metopirone.®

Relative potency data are frequently employed by manufacturers in promoting their products, the implication being that greater relative potency is synonymous with greater therapeutic efficacy. Unfortunately, however, potency, which is usually estimated in animals as described above, is not the same as efficacy which refers to the ability of a drug to produce a therapeutically desirable result in patients. Efficacy of corticosteroids is usually assessed by observing the course of a disease, such as rheumatoid arthritis, when patients are transferred from one product to another. Although useful information can be obtained in this manner, the results are often difficult to interpret because of lack of blinding ran-

(Continued on page 703)

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domization, and the inability to measure end points precisely. Indeed, a truly controlled clinical trial with corticosteroids has not yet been performed.

Another fallacy of the "relative potency argument" is that greater potency is not necessarily an advantage, since the administration of more of a less potent corticosteroid usually produces the same effect. Heightened relative anti-inflammatory potency, for example, is advantageous only if accompanied by lessened mineralocorticoid potency. It is doubtful, however, that a drug such as dexamethasone, which has a relative anti-inflammatory potency of approximately 25, is more efficacious in this regard than triamcinolone, which has an approximate relative anti-inflammatory potency of only 5, since both have very low mineralocorticoid potency.

There are a few situations, however, in which the use of the most potent steroids are clearly desirable: one is in the treatment of infants where the volume of administered material might constitute a problem and another is in the dexamethasone-ACTH suppression test where the great potency of dexamethasone permits administration of a very small amount, thus, not confusing the interpretation of the resulting plasma cortisol level by iatrogenic introduction of corticosteroid into the plasma.

Onset and Duration of Action

Information on the time-activity courses of the corticosteroids in patients is incomplete. In an effort to obtain such data, questionnaires were sent to the major marketers of branded corticosteroid products in the United States. Each was requested to describe the onset of action, time of peak action, and duration of action of its products when administered to an otherwise healthy adrenalectomized patient for maintenance therapy. Although all of the 13 companies responded, the replies were uniformly disappointing: none contained adequate data; only six contained any data at all; and most admitted candidly that the questions could not be answered because the data do not exist. Those data which were supplied described rates of decline of plasma steroid levels (plasma half-life) or durations of eosinophil and/or ACTH suppression in experimental animals and healthy

TABLE 1. Relative Potency of Corticosteroids

Generic Name	Relative Anti-inflammatory Potency	Relative Sodium-Retaining Potency
Cortisone	0.8	0.8
Hydrocortisone	1.0	1.0
Desoxycorticosterone	0.0	100.0
Prednisone	4.0	0.8
Prednisolone	4.0	8.0
Methylprednisolone	5.0	0.5
Triamcinolone	5.0	0.0
Fludrocortisone	10.0	125.0
Fluprednisolone	16.0	2.0
Paramethasone	10.0	0.0
Betamethasone	25.0	0.0
Dexamethasone	25.0	0.0

human volunteers (biologic half-life) rather than clinical end points such as times to relief of symptoms or abnormal signs.

Nevertheless, it is generally believed that the biologic half-lives of corticosteroids approximate their durations of anti-inflammatory action⁵ and, on this basis, they can be divided roughly into three groups: (1) cortisone and hydrocortisone having the shortest durations of action, less than 12 hours; (2) betamethasone and dexamethasone having the longest durations of action, greater than 36 hours; and (3) prednisone, prednisolone, methylprednisolone, fludrocortisone, fluprednisolone, paramethasone, and triamcinolone having durations of action which are intermediate

Different esters of the same corticosteroid may have different rates of absorption, peak levels, and durations of action. For example, the water-soluble phosphate and succinate esters, which can be administered either intravenously or intramuscularly, are absorbed more rapidly and give higher plasma levels than do the acetate and diacetate esters which form suspensions and should not be administered intravenously. The tertiary butyl acetate, trimethyl acetate, and hexacetomide suspensions are absorbed most slowly and, therefore, are best suited for intrasynovial use. In the absence of circulatory collapse, there is little difference between steroid plasma level obtained following subcutaneous, intramuscular, or intravenous administration of water-soluble preparations.

The phosphate esters give higher plasma levels than do the succinate esters. Melby⁶ found that the administration of 1.0 mg per kg of hydrocortisone phosphate intramuscularly to normal volunteers gave a peak plasma 17-hydroxycorticosteroid level at 60 minutes of 125 mcg per 100 ml vs 82 mcg per 100 ml for hydrocortisone succinate. In the case of prednisolone, the peak level was 100 mcg per 100 ml for the phospate vs 93 mcg per 100 ml for the succinate. Similar experiments in dogs gave a peak level of 225 mcg per 100 ml for dexamethasone phosphate vs 125 mcg per 100 ml for dexamethasone succinate.

Cost

There is currently great interest in the cost of medical care. It is appropriate, therefore, that physicians be aware of the wide differences that exist between the prices of various corticosteroid products. It must be emphasized at the onset of this discussion, however, that the cheapest preparation is not necessarily the best one and that other factors such as the reputation of the manufacturer for quality must be weighed as well.

The average wholesale price (AWP)* of the branded plus a sampling of the unbranded (generic) corticosteroid products available in the United States are shown in Table 2. For completeness, mineralocorticoid and corticotropin preparations are included as well. The cost figures were obtained almost entirely from the 1973

^{*}The AWP is the average price charged drugstores (not hospital pharmacies) by the pharmaceutical firms.

Table 2. Adrenocorticosteroid and Adrenocorticotropin Products Available in the United States

Route of Administration	Generic Name	Trade Name	Manufacturer	How Supplied	Average Wholesale Price Per Tablet, Ampule, or Vial (1973)*	Relative Cost (1973)
Oral Cortisone acetate USP	Cortisone acetate USP	Cortisone acetate	Upjohn	5 mg tablet 10 mg ''	\$00.028 .052	\$0.140
		Cortisone acetate	Ormont	25 mg '' 5 mg ''	.110 .008	.110
	Hydrocortisone USP	Cortef®	Upjohn	25 mg '' 5 mg ''	.037 .022	.037
	riyarocornsone osi	Correcto	o pio	10 mg '' 20 mg ''	.040 .077	.080
		Hydrocortisone	McKesson	10 mg '' 20 mg ''	.027 .047	.054
		Hydrocortisone	Ormont	10 mg ''	.014	.028
	Prednisone USP	Delta-Dome®	Dome	20 mg '' 5 mg ''	.025 .050	.02!
		Deltasone®	Upjohn	2.5 mg ''	0.21 .019	.042
				5 mg '' 50 mg ''	.184	.01
		Deltra	Merck Sharp & Dohme	5 mg ''	.026	.02
		Meticorten®	Schering	5 mg ''	.022	.02
		Orasonetm	Rowell	I mg '' 5 mg ''	.011	.05!
				10 mg '' 20 mg ''	.035 .060	.018
		Prednisone	McKesson	2.5 mg ''	.019	.038
		Prednisone	Ormont	5 mg '' I mg ''	.016	.032
		rredinsone	Ottilolii	2.5 mg ''	.007	.014
		Prednisone	Philips Roxane	5 mg '' 20 mg ''	.009 .080	.020
	Prednisolone USP	Delta-Cortef®	Upjohn	5 mg ''	.029	.029
		Prednisolone	McKesson	2.5 mg '' 5 mg ''	.019 .017	.031
			Ormont	I mg ''	.025	.010
		Sterane®	Pfizer	5 mg '' 5 mg ''	.010 .043	.010
	Methylprednisolone NF	Medrol®	Upjohn	2 mg ''	.098	.196
				4 mg '' 16 mg ''	.187 .57 6	.187
		Medrol Medules®	Upjohn	2 mg T.D. capsule	.098	.196
	Meprednisone	Betapar®	Parke, Davis	4 mg '' '' 4 mg ''	.187	.187
	Fluprednisolone NF	Alphadrol®	Upjohn	0.75 mg ''	.080	_
	Paramethasone acetate NF	Haldrone®	Lilly	1.5 mg '' I mg ''	.158	.160
				2 mg ''	.159 .048	.15
	Triamcinolone	Aristocort®	Lederle	1 mg '' 2 mg ''	.097	.19
				4 mg '' 8 mg ''	.188	.181
		V	C ! L L	16 mg ''	.570	.14:
		Kenacort®	Squibb	1 mg '' 2 mg ''	.056 .112	.22
	8etamethasone NF	Celestone®	Schering	8 mg '' 0.6 mg ''	.360 .162	.180
	Dexamethasone NF	Decadron®	Merck Sharp			
			& Dohme	0.25 mg '' 0.5 mg ''	.058 .104	.174
				0.75 mg '' 1.5 mg ''	.130 .230	.130
		Deronil®	Schering	0.75 mg ''	.172	.172
		Gammacorten®	Ciba	0.75 mg ''	.059	.059
		Hexadrol®	Organon	0.75 mg ''	.100	.150
Oral (liquid)	Triamcinolone USP	Aristocort®		1.5 mg ''	.170	.085
		Diacetate Susp Kenacort®	Lederle	120 cc bottle 2mg/5c	c 3.06	.255
	Betamethasone NF	Diacetate Syrup	Squibb	120 cc '' 4mg/5c		.271
	Hydrocortisone USP	Celestone® Syrup Cortef® Syrup	Schering Upjohn	120 cc '' 0.6mg/5c 120 cc '' 10mg/5c		.243
	Dexamethasone NF	Decadron® Elixir	Merck Sharp	•		
		Hexadrol® Elixir	& Dohme Organon	100 cc '' 0.5mg/5c 120 cc '' 0.5mg/5c		.240
Intramuscular	Cortisone acetate USP	Cortisone® Acetate	Upjohn	20 cc vial 25mg/co	6.19	.310
	Hydrocortisone acetate USP	Cortef® Acetate	Upjohn	5 cc '' 50mg/cc 5 cc '' 25mg/cc		.501
		Cortril Acetate Hydrocortisone Acetate	Pfizer Merck Sharp	,		.350
	Hydrocortisone	Hydrocortisone Phosphate	& Dohme Merck Sharp	2 00 209, 00	3.00	.480
	phosphate USP	,	& Dohme	2 cc '' 100mg/cc	2.40	.240

^{*1973} American Druggist 8lue Book. Average wholesale price based on lots of 100 tablets.

^{*}Intralesional

‡Diagnostic use only

§1975 AWP

Table 2. Adrenocorticosteroid and Adrenocorticotropin Products Available in the United States

Route of Administration	Generic Name	Trade Name	Manufacturer	How Supplied		Average Wholesale Price Per Tablet, Ampule, or Vial (1973)*	Relative Cost (1973)
	Hydrocortisone sodium succinate USP	Solu-Cortef®	Upjohn	2 cc '' 2 cc '' 4 cc '' 8 cc ''	50mg/cc 125mg/cc 125mg/cc 125mg/cc	3.00 7.33 14.25 26.96	.600 .586 .570
	Prednisolone sodium phosphate NF	Hydeltrasol®	Merck Sharp & Dohme	2 cc '' 5 cc ''	20mg/cc 20mg/cc	3.84 8.40	.48
	Prednisolone sodium succinate NF Methylprednisolone	Meticortelone® Soluble	Schering	l cc ''	50mg/cc	4.26	.42
	succinate	Solu-Medrol®	Upjohn	2 cc '' 4 cc '' 8 cc '' 16 cc''	20mg/cc 31.25mg/cc 62.50mg/cc	3.85 10.22 34.76	.38! .32 .27
	Triamcinolone diacetate NF	Suspension Aristocort®	Lederle	5 cc '' cc '' 5 cc ''	62.50mg/cc 25mg/cc† 40mg/cc 40mg/cc	59.10 7.14 2.25 11.40	.23 .23 .22!
	Dexamethasone sodium phosphage NF	Decadron® Sodium Phosphate	Merck Sharp & Dohme	l cc '' 5 cc ''	4mg/cc 4mg/cc	1.86 7.20	.37:
	Dexamethasone acetate	Decadron-L.A.®	Merck Sharp & Dohme	25 cc '' 5 cc ''	4mg/cc 8mg/cc	27.93 11.00	.224
		Hexadrol® Phosphate	Organon	l cc '' 5 cc ''	4mg/cc 4mg/cc	1.35 6.00	.270
Intravenous or Intramuscular	Hydrocortisone phosphate USP	Hydrocortisone Phosphate	Merck Sharp & Dohme	2 cc ''	100mg/cc	2.40	.240
	Hydrocortisone sodium succinate USP	Solu-Cortef®	Upjohn	2 cc '' 2 cc '' 4 cc '' 8 cc ''	50mg/cc 25mg/cc 25mg/cc 25mg/cc	300 7.33 14.25 26.96	.600 .586 .570
	Prednisolone sodium phosphate USP	Hydeltrasol®	Merck Sharp & Dohme	2 cc '' 5 cc ''	20mg/cc 20mg/cc	3.84 8.40	.480
	Prednisolone sodium succinate NF Methylprednisolone succinate	Meticortelone® Soluble Solu-Medrol®	Schering Upjohn	5 cc '' 2 cc '' 4 cc '' 8 cc '' 16 cc ''	10mg/cc 20mg/cc 31.25mg/cc 62.50mg/cc	4.26 3.85 10.22 34.76	.426 .385 .327
	Dexamethasone sodium phosphate NF	Decadron® Phosphate	Merck Sharp & Dohme	1 cc '' 5 cc '' 25 cc ''	4mg/cc 4mg/cc 4mg/cc 4mg/cc	59.10 1.86 7.20 27.93	.236 .372 .288 .224
		Hexadrol Phosphate	Organon	I cc '' 5 cc ''	4mg/cc 4mg/cc	1.35 6.00	.270
ntrasynovial Betamethasone sodium- phosphate + betamethason acetate NF	Celestone® Sqluspan®	Schering	3 cc ''	tamethasone - 3 mg sone	10.15		
	Hydrocortisone acetate USP Prednisolone acetate USP Prednisolone	Cortef® Acetate Meticortelone® Acetate Hydeltra-T.B.A.®	Upjohn Schering Merck Sharp	5 cc vial 5 cc ''	50mg/cc 25mg/cc	6.26 4.95	
	butyl acetate Triamcinolone hexacetomide	Suspension Aristospan®	& Dohme Lederle	5 cc '' 1 cc ''	20mg/cc 20mg/cc	4.29 2.84	
	Triamcinolone diacetate NF	Suspension Aristocort®	Lederle	5 cc ''	40mg/cc	11.40	
	Dexamethasone acetate	Decadron-L.A.®	Merck Sharp & Dohme	5 cc ''	8mg/cc	_	
Mineralocortic Oral	Fludrocortisone acetate Desoxycorticosterone	Florinef® Acetate Percorten® Acetate	Squibb Ciba	0.1 mg tab¦et 2.0 mg ''		.026 .096	
Intramuscular	acetate USP Desoxycorticosterone acetate	Linguets® Percorten® Acetate in Oil	Ciba	100 cc vial	5mg/cc	7.000	
	Desoxycorticosterone pivalate NF	Percorten® Privalate	Ciba	4 cc ''	25mg/cc	12.000	
Subcutaneous Repository	Desoxycorticosterone acetate NF	Percorten® Acetate Pellets	Ciba	25 mg pellet		16.250	
Adrenocortico Intravenous or	tropin Preparations Corticotropin						
Intramuscular	injection	Acthar® ACTH	Armour Parke, Davis	2 cc vial 2 cc ''' 10 cc ''	25u/vial 50u/vial 25u/cc	1.93 2.96 1.50	
Intravenous	Cosytropin, snythetic 1-24 corticotropin‡	Cortrosyn®	Organon	10 cc ''	40u/cc .25mg/vial	2.86 2.30§	
Intramuscular	Repository corticotropin injection	H.P. Acthar® Gel	Armour	1 cc '' 5 cc '' 1 cc ''	40u/cc 40u/cc 80u/cc	1.45 2.67 2.53	
	Corticotropin zinc	Cortrophin®-Zinc	Organon	5 cc '' 5 cc ''	80u/cc 80u/cc	4.13 3.40	

^{*1973} American Druggist Blue Book. Average wholesale price based on lots of 100 tablets. †Intralesional ‡Diagnostic use only §1975 AWP

American Druggist Blue Book⁷ and, in a very few instances, from a company representative directly and should not be interpreted as current or recommended prices. Most of the prices have changed since 1973, and they are included only to assist the reader in assessing their relative cost. Since the products vary widely in potency, the concept of "relative price" is suggested. For purposes of this discussion "relative price" is arbitrarily defined here as the price of that amount of the product under consideration which has an anti-inflammatory potency theoretically equivalent to 20 mg of hydrocortisone administered via the same route. It is derived by multiplying the AWP per mg of product by 20 divided by the relative anti-inflammatory potency factor given for the product in Table 1. Relative cost has not been computed for corticotropin and mineralocorticoid preparations.

It can be readily appreciated from the figures in Table 2 that, despite their theoretically equal antiinflammatory potencies, a 25-mg tablet of cortisone acetate or a 20-mg tablet of hydrocortisone can cost one-half
to 12 times as much as a 5-mg tablet of prednisolone
which, in turn, can cost as little as one-ninth to one-half
as much as an 0.75-mg tablet of dexamethasone! Similarly,
hydrocortisone sodium succinate and dexamethasone sodium phosphate can cost three times as much as equivalent amounts of prednisolone phosphate, hydrocortisone
phosphate, and triamcinolone diacetate, all of which cost
approximately the same. The cost of different esters of
the same corticosteroid also can vary widely, ie, \$1.20 for
100 mg of hydrocortisone phosphate vs \$3.00 for 100 mg
of the succinate. This is of particular interest because, in

general, the phosphate esters have the advantage of yielding higher and longer lasting blood levels. The AWPs of apparently identical compounds marketed by different manufacturers also may vary widely. The cost of a 20-mg tablet of hydrocortisone, for example, can vary from 2.5 to 7.7 cents and that of a 5-mg tablet of prednisone from 0.9 to 5.0 cents depending on which firm's product is selected. Finally, the cost of a particular preparation can vary widely depending on the tablet or vial size, ie, two 10-mg tablets of hydrocortisone cost more than a single 20-mg tablet.

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Biopsy-Confirmed Sarcoid Interstitial Fibrosis After a 15-Year Remission

Mark R. Schuyler, M.D. Dennis E. Niewoehner, M.D. Jerome I. Kleinerman, M.D.

Although sarcoidosis eventually may progress to interstitial fibrosis, radiologic clearing of parenchymal infiltrates is thought to indicate permanent remission. Presented in this article is the first pathologically confirmed instance of interstitial fibrosis appearing after a prolonged period of normal chest roentgenologic and symptomatic remission.

SARCOIDOSIS is a systemic granulomatous disease in which pulmonary involvement may progress to diffuse interstitial fibrosis. However, it is rare for parenchymal infiltration to reappear after prolonged radiologic remission. 1-5 The patient described here had clearly documented sarcoidosis which remitted completely for 15 years concomitant with a short course of corticosteroid therapy, and then presented with symptomatic, radiologic, and pathologic evidence of diffuse interstitial lung fibrosis.

Clinical Observations

A 47-year-old black woman developed iridocyclitis and bilateral hilar adenopathy in July 1955. In October 1955, she began to notice fatigue, orthopnea, paroxysmal nocturnal dyspnea, anorexia, and weight loss. A tender, subcutaneous leg nodule was biopsied in December 1955 and revealed perivascular noncaseating granulomata and fibrinoid necrosis of vascular walls. Her chest x-ray film, in January 1956, demonstrated diffuse infiltrates as well as the previously noted bilateral hilar adenopathy (Fig. 1). A Kveim test was positive, and a scalene lymph

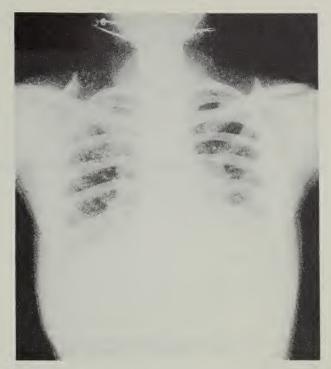


Fig 1. Chest x-ray film of patient in January 1956.

node biopsy showed noncaseating granulomata that were negative for tubercle bacilli and fungi. The diagnosis of sarcoidosis was made: therapy was begun with 200 mg hydrocortisone per day and, one month later, her vital capacity had increased to 2.0 liters from 1.2 liters (predicted 3.4 L). Corticosteroid doses were tapered and stopped altogether by July 1956, at which time she was

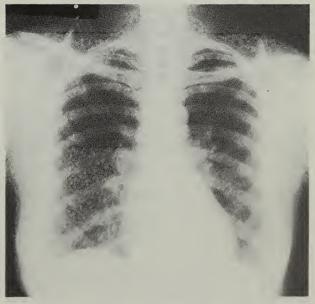


Fig. 2. Representative normal chest x-ray film of patient from 1957 to 1972.

Dr. Schuyler, Cleveland, Fellow in Medicine, St. Luke's Hospital.

Dr. Niewoehner, Cleveland, Assistant Professor of Medicine, Case Western Reserve University School of Medicine. Dr. Kleinerman, Cleveland, Director of Pathology Research, St. Luke's Hospital; and Professor of Pathology, Case Western Reserve University School of Medicine.

Reprint requests to Department of Pathology Research, St. Luke's Hospital, 11311 Shaker Boulevard, Cleveland, Ohio 44104 (Dr. Schuyler). Submitted January 10, 1975.

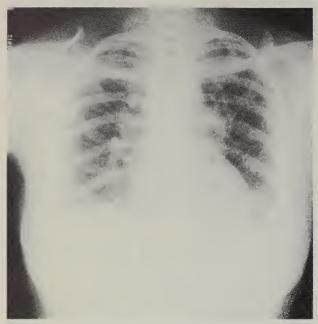


Fig. 3. Chest x-ray film showing hilar adenopathy and diffuse infiltrates in November 1972.

asymptomatic. Her chest x-ray film was normal by February 1957, and the vital capacity progressively improved to 2.6 liters by 1958. Figure 2 is a representative normal chest film during the period of 1957 to 1972.

In November 1972, seventeen years after the appearance of sarcoidosis and 15 years after radiologic and symptomatic remission, dyspnea, orthopnea, and paroxysmal nocturnal dyspnea recurred and her chest x-ray film again demonstrated hilar adenopathy and diffuse infiltrates (Fig. 3). A lingular and left hilar node biopsy was performed and revealed advanced interstitial fibrosis with scattered giant cells but no distinct granulomata (Fig. 4). The hilar node contained many noncaseating, partially hyalinized granuloma without giant cells. Results of stains and cultures for tubercle bacilli and fungi were negative.

Because her vital capacity had decreased to 1.4 liters and single-breath diffusing capacity was 63 percent of predicted, she has been treated with prednisone, 50 mg/day, but without improvement to date (January 1975).

Comment

Although sarcoidosis may progress to, or present with, pulmonary interstitial fibrosis when parenchymal infiltrates clear and symptomatic remission occurs, relapse is rare. Furthermore, no reported case has had biopsy confirmation that the recurrent disease was indeed sarcoidosis.

Siltzbach² mentioned two patients who relapsed with parenchymal lesions three and seven years after clearing of infiltrates, but he did not note results of

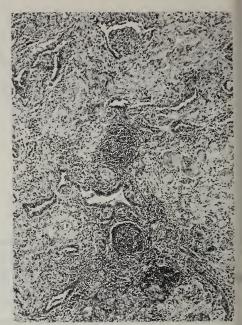


Fig. 4. Photomicrograph of specimen obtained in lung biopsy in September 1973. Normal pulmonary architecture is replaced by collagen, fibroblasts, collection of lymphocytes, and scattered giant cells. Few remaining air spaces are lined by atypical respiratory epithelium.

biopsies or steroid therapy. Sones and Israel¹ reported the case of a 23-year-old woman with bilateral hilar adenopathy and parenchymal infiltrates who received corticosteroids and whose radiologic abnormalities cleared. However, the infiltrates reappeared 16 months later and then disappeared again one year thereafter. The only pathologic evidence of sarcoidosis was a compatible cervical-node biopsy at the beginning of her illness. Other large series3-5 revealed no relapses in patients who achieved a normal chest roentgenogram.

Although radiologic clearing is usually associated with an excellent prognosis, there is evidence that the pathologic process is not completely reversible even when the radiologic manifestations remit completely. Diffusing capacity may be decreased⁶⁻⁸ and lung biopsies after x-ray clearing may show focal interstitial fibrosis.3,7

This manuscript documents pathologically that pulmonary sarcoidosis can relapse many years after apparent radiologic and symptomatic remission. The transient corticosteroid therapy might have altered the pathologic processes so as to delay the ultimate appearance of pulmonary fibrosis.

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A Generalist's Approach to Diagnostic Chest X-ray

Henry Bachman, M.D.

PHYSICAL EXAMINATION of the chest has undergone a basic change during my lifetime. Auscultation has been refined with new and more sophisticated stethoscopes. Percussion, however, has declined as a clinical tool in favor of x-ray diagnosis. Yet, I still can pinpoint a small, peripheral pleural effusion best by percussion.

A more dramatic change has taken place in the area of pulmonary function testing - not that we did not have most of the diagnostic means at our disposal: vital and timed vital capacity testing; walking and other exercise tests; and blood gas determinations. They all were in the tool chest for some time, but they were used only on a limited scale by the experts.

With the recent advent of the black lung legislation, pulmonary function testing has become a standard, and in many cases, a computerized procedure. I am all for the medical and social progress contemplated by the black lung laws. In time, they well may lead to the elimination of "miner's asthma" - at least as far as it is caused by the effects of poor mining hygiene - just as silicosis laws changed that epidemic disease into a rare and endemic one.

Early pulmonary function testing, usually performed or supervised by the chest physician, frequently furnished pertinent medical impressions about the patient, his breathing efforts, and his physical and psychological condition, all of which aided in both the evaluation and care of the patient.

Today, we seem more interested in organized and legislated benefits, pensions, and paramedical efforts at rehabilitation which, at least in some cases, are of questionable benefit considering the basic underlying anatomic

Under the present system, little room is left for the generalist to make preliminary evaluation of breathing deficiencies as he would attempt to make preliminary evaluations of cardiac deficiencies prior to the patient's referral to a specialist. In the pulmonary disease field, the generalist usually sends his patient-claimant to a pulmonary function center or to a claims lawyer without preliminary evaluation.

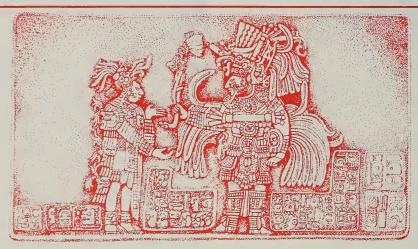
There is a simple test which might well be used as a preliminary guide in problems concerning pulmonary function. A set of inspiratory and expiratory chest x-ray films is made at the routine 72-inch distance, without the patient changing position between inspiration and expiration and with a rapid change of the x-ray plates. The developed expiratory x-ray film should then be positioned on the view box and the inspiratory x-ray film overlaid with the images of both clavicles overlapping exactly. The expiratory phase of the diaphragms then can be marked with a soft red pencil on the inspiratory film. Measurements of the excursions of both diaphragms in forced inspiration and expiration and the concomitant changes in cardiac silhouettes, chest cages, and lung fields can reveal a great deal about the mechanical function of the pulmonary cage. Surprisingly, the degree of lung fibrosis often does not coincide with the ability to move the diaphragm. Even some advanced cases of fibrosis may have fairly good diaphragmatic excursion and function. On the other hand, many cases of basal emphysema with little or no signs of fibrosis show marked restriction of the diaphragmatic movements.

With a modicum of experience, the generalist or the specialist can foretell from this simple test, with a fair degree of accuracy, the expected results of more sophisticated pulmonary function testing. Hence, the treating physician can give the patient knowledgeable advice rather than sending him off blindly to a regional testing center or to a claims attorney.

Dr. Bachman, McConnelsville, Medical Director (retired), Rocky Glen Sanatorium and Mark Rest Center, McConnelsville; and Courtesy Staffs, Bethesda Hospital and Good Samaritan Medical Center, Zanesville. Submitted June 12, 1975.

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Ohio Health News

John H. Ackerman, M.D., M.P.H.

Director of Health

Following is an excerpt from a report made by Dr. Ackerman at the 56th Annual Conference of Ohio Health Commissioners on September 10, 1975.

"In the communicable disease sector, the major effort of the Epidemiology Unit has been concentrated toward hepatitis. In the past year, there were 1,192 cases of infectious hepatitis and 271 cases of serum hepatitis. We were successful in our assistance for the passage of a bill to regulate plasma pheresis centers in Ohio. This should provide donors to these establishments protection against hepatitis B that has not existed up to this time.

"We participated in an influenza surveillance program that saw 9,215 cases being reported. It is hoped that further improvements in this system will enable us not only to recognize the influenza potential in Ohio for a given year, but to assist the Communicable Disease Center in its national effort.

"An infection control program for nosocomial infections was initiated and two extensive surveys of Ohio's hospitals were made. This information will enable us to identify the needs of the state in this area and provide training programs for infection control personnel in order that all hospitals will attain the desired level of competency.

"Éfforts have been made to increase reporting at the local level. Communicable disease personnel have been making special efforts to get local departments and physicians to be more aware of their obligations in this area. It is essential to a good surveillance system and disease control that there be good reporting at the local level.

"Our Vector Borne Disease Unit has conducted surveys in 16 communities and given follow-up assistance to local health departments. This particular activity could be greatly expanded because the demand for more help is there as people become more aware that summer spraying is not adequate.

"During 1974, we saw only three cases of California encephalitis, the lowest number since this program was initiated in 1964. This is largely due to the extremely dry weather experienced last summer. Some research has been carried out in pursuit of establishing the life cycle of this disease. Transovarial transmission studies were made of the tree hole mosquito, the woodland pool mosquito, and the chipmunk's role in this cycle.

"Our Immunization Unit found that the immunization levels of children who entered elementary school last year were higher than in the preschoolers, but still inadequate in many areas. Rural areas in Ohio have the highest total percentage of inadequately immunized children. The greatest number of inadequately immunized firstyear school children remains in urban centers.

"The immunization levels of the school enterers assessment for the last school year was 90.1 percent for polio, 94.1 percent for DPT, 90.5 percent for measles, and 87.8 percent for rubella. For measles, there was an increase over the previous school year of 4.1 percent and an increase for rubella of 3.6 percent.

"During the year, we distributed 1,081,625 doses of DPT, TB, polio, measles, and rubella vaccines to local health departments.

"The Tuberculosis Unit has not experienced any major changes within the past year. However, we did see an increase in the number of general hospitals throughout the state that are accepting tuberculosis patients. Reporting of new cases has improved in some parts of the state. We had 740 newly reported cases within the past 12 months compared to 654 for the preceding 12-month period.

"Subsidy for financial assistance to the local health departments has been approximately \$600,000 per year and is used for treatment for control of tuberculosis. It has been necessary to discontinue all special TB project grants due to cuts in federal funding. This will affect mainly the larger cities.

"Veneral disease continues to be a problem. Last year, primary and secondary infections rose from 279 to 499, an increase of 25.1 percent. Early latent morbidity demonstrated a 31.4 percent jump, with 381 cases reported compared to 290 during the preceding year. Epidemiology performed around the primary and secondary infections led to the initiation of 1,250 contacts resulting in the identification of 121 individuals with early syphilis.

"A total of 564,306 cultures were obtained from females in screening settings with 19,944 found to have findings indicative of gonorrhea. Our laboratory began producing its own media near the end of the year, a move that should result in an increase in the percentage of positive findings.

"A total of 10,894 contact interviews were performed on males with gonorrhea last year. This activity resulted in the identification of 3,242 new gonorrhea infections.

"Rabies has continued to decrease significantly in (Continued on next page)

Health News/continued

Ohio during 1974 and 1975 to date. The total of 32 animal cases reported in 1974 was an all-time low. The 1975 total will very likely be lower yet, with only seven cases reported over the first six months. At least part of the credit can be attributed to record immunization levels of pets and some farm animals. Veterinarians and local health departments have organized pet immunization clinics in many counties.

"Another plus in regard to rabies prevention is the availability of homoloyous anti-rabies serum. This is not designated to replace the old heterologous antiserum except for those who have significant reactions to the old product.

"Reported cases of rheumatic fever and new enrollments in the rheumatic fever drug prophylaxis registry continue to decline in direct relationship to the increase in the use of mail-in strep throat culture services. The ten cooperating public health laboratories processed nearly 500,000 group A strep throat cultures last year. At this time, 16,645 Ohioans are receiving drugs through the central registry to prevent secondary attacks of rheumatic fever.

"The ground work has been laid for epidemiologic surveillance systems of childhood cancer and birth defects. Associations between specific types of cancer and occupational exposure are also being investigated. The purposes of the cancer programs are to: identify subgroups of the child population that are at an increased risk of developing cancer; determine whether or not there are specific areas of the state where children are being presented for initial cancer treatment at relatively later stages of the disease, with the end result of a decreased chance for survival; and determine whether or not specific types of cancer in the adult population are related to occupational exposure.

"The first year of our Cervical Cancer Screening Program concluded with 20 rural counties conducting regular clinics for sexually active women over age 16 who had never had a Pap test, or had not had one within the past year. A total of 6,319 women were screened in the first year, with 54 percent of these over 40 years of age, 63 percent from poverty and low income groups, and 14 percent never having had a Pap test. Eight positive and 14 suspicious results were recorded.

"A total of 12 alcoholism regions are now organized and staffed to complete the state network of alcoholism services. Since last year's conference, additional regional council offices have been established in Athens, Cambridge, Lima, Mansfield and Youngstown.

"Our staff has processed more than 200 applications for state alcoholism funds. Project applications varied from proposed one-day seminars to treatment programs costing up to half a million dollars. In addition to projects funded by the state, our staff provided technical assistance to approximately 35 projects that had direct federal assistance."

IMPORTANT INFORMATION: This is a Schedule V substance by Federal law; diphenoxylate HCI is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCI) or Narcan® (naloxone HCI) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

sensitive to diphenoxylate HCI or atropine.

Warnings: Use with special caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCI may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis. In severe dehydration or electrolyte imbalance, withhold Lomotil until corrective therapy has been initiated.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCI and atropine are secreted in the breast milk of nursing mothers.

breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCI is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage. Use with care in patients with acute ulcerative colitis and discontinue use if abdominal distention or other symptoms develop.

Adverse reactions: Atropine effects include dryness

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing, hyperthermia, tachycardia and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria, paralytic ileus, and toxic megacolon.

caria, paralytic ileus, and toxic megacolon.

Dosage and administration: Lomotii is contraindicated in children less than 2 years old. Use only Lomotii liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, hyperthermia, tachycardia, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils and respiratory depression which may occur 12 to 30 hours after overdose, Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. A narcotic antagonist may be used in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. Liquid, 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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comments

Are We Fair to the Defendant?

Unreasonable liability claims are an unjustifiable threat to individuals and, by sheer volume, obstruct and delay administration of justice. To protect the rights of everyone, a "Defendant's Rights Bill" must be enacted to restore a fair balance between the plaintiff and the defendant.

Any lawsuit alleging liability should specify the amount of monetary damages claimed. To protect a defendant from wrongful or excessive claims, all persons participating in a plaintiff's action, specifically including professional participants, should be jointly liable to the defendant for such wrongful and excessive claims. This liability should amount to 25 percent of the difference between the original plaintiff's claim and whatever lesser amount is finally awarded. Such liability should be awarded to the defendant immediately upon conclusion of the matter. In the event that payment is delayed, interest would accrue at the rate of 10 percent per year.

Legislation such as the above-proposed "Defendant's Rights Bill" would protect everyone, not just physicians, against unjust and excessive suits. At the same time, it preserves the right of a plaintiff to bring suit in any amount that is actually justified and preserves the lawyer's right to his contingency fee.

Obviously, this legislation eliminates the chance for a "free shot" at the defendant victim, because it would now cost the plaintiff and his lawyer a penalty for having wrongfully damaged their intended victim. Certainly a lawsuit is a premeditated and responsible action with serious consequences to the defendant, and those who press the suit should anticipate a penalty for wrongful actions.

The "malpractice" problem is only a small part of our society-wide runaway liability threat. "Defendant's Rights" legislation could remedy this problem. All parties to the plaintiff's action, including professional counsel, participate in threatening the defendant, hence, all should jointly be subject to the penalty.

One final point — the lawyers are fond of saying that there would be no malpractice suits if doctors would stop making wrong decisions in the urgency of practice. Obviously, if the lawyers, schooled in the arts of justice and deliberating carefully in the quiet of their offices, would refrain from initiating wrongful and excessive lawsuits, then there would be no penalties under this new "Defendant's Rights Bill."

—William H. Havener, M.D. Columbus

Good News, Bad News and Old Wives' Tales

The bad news first . . . Twenty-nine percent of the preschool children in the state of Ohio are inadequately immunized against diphtheria, pertussis, and tetanus; 36 percent are not protected against polio; 43 percent are not protected against rubeola; and 60 percent are not protected against rubella. These statistics obviously vary with the community. Although the problem is most severe in the ghettos, inner cities and rural-poor areas, there are many children in the middle-class suburban and rural areas who are inadequately protected.

Now the good news. Of these same children surveyed, 95 percent have had at least one immunization. This means, therefore, that these children have been incorporated in some program and their immunizations at least started, whether in public or community health programs or in the private physician's office. So, adequate follow-up and return appointments would solve the problem for all practical purposes. We, as practicing physicians, can do our part by seeing that our own private patients' personal immunizations are current. This involves time, but then what doesn't?

Some old wives' tales:

1. If a dose of vaccine is out of schedule, you must "start all over." False.

2. Any evidence of a runny nose contraindicates immunization. False. It is permissible to give immunization under such circumstances if the child is not febrile and has no signs of complicating disease.

3. You must give all the immunizations separately. False. Although it may be comfortable to separate them, they can be given in combination effectively especially if you think you may not get adequate follow-up (i.e., rubeola, rubella, mumps, DPT #1 and polio #1 all given at the same time to a child over one year of age).

October is the emphasis month, but let's keep it in mind all year long.

(Data in this article was extracted from Ohio Department of Health sources and the "Red Book" of pediatrics.)

Robert E. Batterson, M.D.
 Chairman
 Committee on Pediatric Practice
 Ohio Chapter
 American Academy of Pediatrics

Opinions stated in the *Comments* section are those of the individual authors, they do not necessarily reflect the views of OSMA.

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• infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing. CONTRAINDICATIONS: Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components. WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to



neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended. PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



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The

111th Ohio General Assembly

A Special Report From Your Department Of State Legislation

The passage of H.B. 682, the omnibus medical malpractice act, made the first session of the 111th Ohio General Assembly the most significant legislative session in OSMA's history. H.B. 682 required almost the total effort of your Department of State Legislation during the

six months preceding its passage.

Concerned legislators in both Houses also spent long hours working on the act. A special thanks must be given to Representatives: William E. Hinig (D-New Philadelphia), Chairman of the House Insurance, Utilities, and Financial Institutions Committee and one of the prime sponsors of Am. Sub. H.B. 682; Ronald H. Weyandt (D-Akron), Chairman of the subcommittee in the House; and William G. Batchelder (R-Medina), member of the House committee. OSMA is also grateful to the remaining members of the House committee.

Senators Robert E. O'Shaughnessy (D-Columbus) and Tony P. Hall (D-Dayton) also deserve the appreciation of OSMA members. They protected Am. Sub. H.B. 682 from the lobbying efforts of both the Ohio State Bar Association and the United Auto Workers. Thanks to their work, the bill retained many legal reforms, making it "the most sophisticated piece of legislation presently in the country" (according to James H. Sammons, M.D., Executive Vice President of the AMA).

Although its attention centered on the malpractice act, your Department of State Legislation supported or opposed many other bills that ultimately became laws. Twenty bills affecting the medical profession were passed by both Houses of the General Assembly and signed by the Governor. OSMA was actively involved in many of

these bills, and monitored others for information and study. Following is a short summary of some of the legislation passed before September 1 in the 111th General Assembly.

Am. Sub. H.B. 300, Wilkowski (D-Toledo), revises Ohio's drug abuse prevention and control laws. This bill reduces the penalties for unlawful possession of small amounts of marihuana to a minor misdemeanor, and it increases the penalties for the unlawful possession of most other controlled substances. It requires specified prison terms for persons guilty of corrupting another with drugs, illegal trafficking in drugs, or theft of drugs. It also establishes an Ohio Drug Treatment Advisory Council and establishes procedures for therapy and treatment in lieu of conviction for drug dependent criminals.

Am. S.B. 283, Carney (D-Girard), requires persons who treat individuals for burns to report to the police any second or third degree burns caused by an explosion or incendiary device or inflicted in a violent, malicious, or criminal manner.

Am. Sub. S.B. 144, Valiquette (D-Toledo), Ohio's new rape act, signed August 27, 1975 by the Governor. It changes the rules of evidence and requires a pre-trial hearing in private to determine whether evidence that can be submitted to the jury is material.

Am. H.B. 229, Fries (D-Dayton), establishes a College of Osteopathic Medicine at Ohio University. It appropriates \$670,000 for the 1975-1977 biennium for planning for the college and requires 80% of the students to be Ohio residents.

(Continued on next page)

Am. Sub. H.B. 137, Lehman (D-Cleveland), requires group health care and hospital service contracts, and group policies of hospital, surgical, or medical expense insurance, to contain an option for conversion to an individual contract upon termination of membership in the group.

Am. S.B. 152, Pease (D-Oberlin), permits contracts of hospital service associations to include community mental health services as part of the contract.

Am. S.B. 263, Woodland (D-Columbus), authorizes state colleges and universities with medical school teaching hospitals (The Ohio State University and The Medical College at Toledo) to purchase liability insurance for agents, employees, students, nurses, interns, and resident physicians of their clinical teaching or research hospitals.

Am. Sub. H.B. 250, Kopp (D-Columbus), limits the liability of the county of residence of a patient undergoing treatment for tuberculosis at The Ohio State University Hospital to the amount not covered by health insurance.

Am. H.B. 554, Stinziano (D-Columbus), prohibits the collection of plasma by plasmapheresis except by an

establishment that is certified by the Director of Health as complying with federal and state regulations or by a hospital. The Director of Health has authority to investigate and examine existing establishments that conduct plasmapheresis to replace the federal testing that had been taking place up to now.

Am. H.B. 705, Mallory (D-Cincinnati), establishes a Nursing Home Advisory Commission to study the operation and regulation of nursing homes and to make recommendations to the General Assembly annually.

Am. Sub. H.B. 908, Deering (D-Monroeville), provides for state participation in the National Health Planning and Resources Development Act of 1974; directs the Public Health Council to coordinate and implement health planning and development activities under the federal act through the Department of Health agreements with HEW regarding capital expenditures under maternal and child health, crippled children, Medicare and Medicaid programs.

Am. S.B. 14, Applegate (D-Steubenville), permits the extension from January 1, 1975 to January 1, 1976, the deadline by which nursing homes, rest homes, and



DESCRIPTION: Methyltestosterone is 176-Hydroxy-17-Methylandrost-4-en-3-one. ACTIONS: Methyltestosterone is an oil soluble androgenic hormone. INDICATIONS: In the male: 1. Euruchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. PRECAUTIONS: Prolonged dosage of androgen may result in sodium and full retention. changes appear to be related to dosage of the drug. I nerefore, in the presence of any changes in liver function tests,
drug should be discontinued. PRECAUTIONS: Prolonged
dosage of androgen may result in sodium and fluid retention.
This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males
for symptoms of climacteric, avoid stimulation to the point of
increasing the nervous, mental, and physical activities
beyond the patient's cardiovascular capacity.
CONTRAINDICATIONS: Contraindicated in persons with
known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence
of severe liver damage. WARNINGS: If priapism or other
signs of excessive sexual stimulation develop, discontinue
therapy. In the male, prolonged administration or excessive
dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use
cautiously in young boys to avoid premature epiphyseal
closure or precoiculs sexual development. Hypersensitivity
and gynecomastia may occur rarely. PBI may be decreased
in patients taking androgens. Hypercalcemia may occur,
particularly during therapy for metastatic breast carcinoma.
If this occurs, the drug should be discontinued. ADVERSE
BEACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia may cour,
particularly with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water
retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. DOSAGE AND
ADMINISTRATION: Dosage must be strictly individualized,
as patients vary widely in requirements. Daily requirements
are best administered in divided doses. The following is
suggested as an average daily dosage guide. In the male:
Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency,
10 to 40 mg.; Postpubleral cryptorchism,

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homes for the aged must have automatic fire protection systems.

Am. S.B. 55, Bowen (D-Cincinnati) permits the care of persons with active pulmonary tuberculosis in a nursing home, rest home, or home for the aging, under certain conditions.

Am. H.B. 662, Camera (D-Lorain), permits the Rehabilitation Services Commission, the Amputee Clinic at The Ohio State University Hospital, or an amputee clinic or physician approved by the Bureau of Workmen's Compensation or the Industrial Commission to determine an injured or disabled employee's need for a prosthetic device, and requires the Industrial Commission to pay for a prosthetic device once a determination of need is made.

Am. Sub. H.B. 79, Roberto (D-Ravenna), creates a State Board of Speech Pathology and Audiology to license and regulate the practices of speech pathology and audiology, and prohibits their practice without a license. Sets standards for the practice of speech pathology and audiology and excludes M.D.'s and persons working under the direction of M.D.'s from the requirements of the Act.

Am. S.B. 75, Headley (D-Barberton), establishes a Chiropractic Examining Board and transfers to it the powers and duties now held by the State Medical Board pertaining to the practice of chiropractic. Defines the practice of chiropractic and sets minimum qualifications for licensure. In addition, it places chiropractors on the same basis as physicians with respect to payment of the cost of medical services provided beneficiaries of workmen's compensation and recipients of medical assistance.

Am. S.B. 201, Secrest (D-Cambridge), adds one member to the State Medical Board and requires him to be a Doctor of Podiatric Medicine (DPM). (Remember, Am. Sub. H.B. 682 added another member to the State Medical Board increasing the total membership to seven M.D.'s, one D.O., one D.P.M., and one consumer.)

Am. Sub. H.B. 23, Camera (D-Lorain), provides a homestead exemption for disabled persons, as determined by a physician

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ACTION AND USES — DOSAGE: 1 tablet after breakfast and supper, or as required. In females, 3-week courses of therapy are recommended followed by a 1-week rest period. Withdrawal bleeding may occur during the rest period. PRECAUTIONS: Administer cautiously to female patients who tend to develop excessive hair growth or other signs of masculinization. CONTRAINDICATIONS: Patients in whom estrogen or androgen therapy should not be used, as in carcinoma of the breast, genital tract, or prostate, and in patients with a familial tendency to these types of malignancy. AVAILABLE: Bottles of 100 and 500 tablets. Rxonly.

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Colonial Medicine In Cincinnati

Arthur G. King, M.D.

Cincinnati in the late 1700's was a reflection of Colonial American Medicine. Cupping, bleeding, blistering, sweating, purging and puking, together with empiric herbalism, were common treatments. Although Ohio was not one of the Thirteen Colonies, its early physicians had all been trained in the East.

In 1789, Cincinnati (then called Losantiville) consisted of 11 families and 24 single men. Under the direction of the United States War Department, a fairly pretentious fort was built east of Broadway between Third and Fourth Streets. It measured 200 feet on each side and was appropriately named Fort Washington. On January 1, 1790, General Josiah Harmar moved 300 men and his headquarters from Marietta to Fort Washington and began to assemble troops to end the Indian depredations.

Dr. Richard Allison, generally considered to be the first physician in the Cincinnati area, was a medical officer on General Harmar's staff. Born in New York in 1757, Allison was a surgeon of the 5th Pennsylvania Regiment during the Revolutionary War.

Allison accompanied General Harmar on the ill-fated expedition of 1790 against the Indians. Proceeding up the valley of the Little Miami River, the troops were defeated at the portage of the Maumee and Wabash Rivers. Among the 1,450 troops, involved, 243 were killed and 31 wounded. The disproportion of dead to surviving

wounded may partly be explained by the fact that surgery was done hastily in the field. Allison was the only trained physician for the entire force. As soon as he returned to Fort Washington, Allison wrote vigorous letters demanding more medical assistance and a hospital.

His first request was answered promptly by the arrival of John F. Carmichael of Pennsylvania, Dr. Joseph Strong of Connecticut, and Surgeon John Elliot of New York. These medical reinforcements may well have been due to the influence of General Arthur St. Clair, Governor of the Northwest Territory.

General Harmar was relieved of command immediately after the defeat of 1790 and St. Clair took personal command of the "Legion," as the army was then called. St. Clair had some medical training and is even listed in the official roster of Medical Men in the American Revolution. However, his fame is far more political than medical or military. He was President of the Pennsylvania Chapter of the Society of the Cincinnati, an organization of officers who had participated in the Revolution. Because of that honor, he ordered the change in name from Losantiville to Cincinnati, which he then made capital of the Northwest Territory.

In 1791, St. Clair set out to avenge General Harmar's defeat. His army of 1,400 soldiers was cut to pieces by the Indians. Allison was again present and is recorded as helping to rally the troops and supervise the withdrawal. Possibly because of the increase in medical staff and his assumption of authority, Allison was able to raise the proportion of surviving wounded to 289 out of 919 casualties. (This was 31 percent as compared to only 11 percent the previous year.) St. Clair hastily disappeared from Cincinnati after his defeat.

Allison's demand for a hospital was finally met in 1791. The War Department at length authorized the

Dr. King is an Assistant Clinical Professor of Obstetrics and Gynecology at the University of Cincinnati Medical College. He is a senior attending obstetrician-gynecologist at the Jewish Hospital in Cincinnati. A graduate of Harvard Medical School, he is a member of the American Association for the History of Medicine.

construction of a hospital at Fort Washington. This was completed in the spring of 1792, consisting of three buildings, two of them 10 by 10 foot, on either side of a two-storied 12-foot-square blockhouse, all protected by a palisade forming a triangle on the north side of the Fort. The War Department 1792 plat of Fort Washington shows this to be an extension reaching almost to Fourth Street, placing it in what is now the yard of the Guilford School. Although it contained less than 500 feet of covered space, plus the open area in the enclosure, it is noteworthy as the first hospital in Cincinnati and perhaps in Ohio.

General "Mad" Anthony Wayne took command of Fort Washington in 1792. He made careful preparations for what was a final and successful campaign against the Indians, culminating in the battle of Fallen Timbers and the Treaty of Greenville. He brought with him two more military surgeons: Dr. John Sellman and Dr. Joseph Phillips. Wayne had numerous problems, such as, poor morale and almost complete disorganization in the troops. There was also marked friction between the military and civilians, especially with the military rendering medical service to civilians.

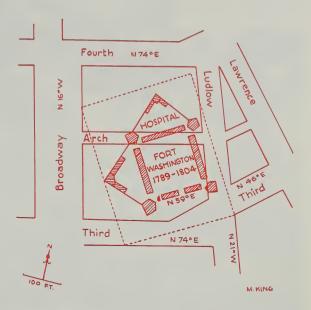
When an epidemic of smallpox started, Wayne moved most of his troops out of the "city" to a hilly area just west of Central Avenue. (By the summer of 1793, about one-third of Cincinnati's population had died.) As more troops arrived, he moved them still farther away, first to Fort Hamilton and then to Greenville, where he made his headquarters. Presumably, Allison and the other army doctors moved with him in the campaign until its ultimate victory at Fallen Timbers in August, 1794.

After the Battle of Fallen Timbers, the six military surgeons went separate ways. Strong and Phillips were transferred. Elliot and Carmichael did only garrison duty at Fort Washington, until in 1802, Elliot went to Dayton to practice privately. John Sellman resigned and set up private practice in Cincinnati on Front Street between Sycamore and Broadway, until his death in 1827. Richard Allison was honorably discharged in 1796 and bought a farm at the junction of Stone Lick Creek and the East Fork of the Little Miami. He was there for nine years, being the only medical practitioner in Butler and Clermont Counties. But he then returned to Cincinnati and had an office at the southwest corner of Fourth and Sycamore Streets from 1805 to 1816.

Before 1794, there were three civilian physicians in Cincinnati. Dr. John Hole was born in Virginia in 1754 and served in the American Revolution from the Battle of Bunker Hill to the War's end. He settled in New Jersey, but in 1788, he came west with the Symmes party and practiced medicine in what is now Columbia. He maintained an office until 1797. Drake credits him with introducing cow-pox inoculation in Cincinnati.

Dr. William Burnet, son of Dr. William Burnet, George Washington's Surgeon-General for the Eastern Department, came to North Bend, Ohio in 1789. He, too, was a veteran of the Revolution, but his military career apparently ended in 1776 after a short stint with

(Continued on next page)



Above: The first hospital in Cincinnati, and perhaps in Ohio, was contained in Fort Washington. The map shows the location of Fort Washington (1789-1804) in relation to modern Cincinnati. Below: A profile of Dr. Richard Allison (1757-1816). Dr. Allison is considered to be the first physician in the Cincinnati area. (Photograph supplied by the National Library of Medicine, Bethesda, Maryland.)



Colonial Medicine/continued

the 1st New Jersey Battalion. (His three younger brothers came to Cincinnati later and achieved fame; Judge Jacob Burnet, a well-known jurist who wrote the Ohio Constitution; Isaac Burnet, the first mayor of Cincinnati as a city; and David Burnet who fought for the independence of Texas and became its first president.) But young Dr. Burnet fell into disgrace in Cincinnati in 1791 and returned to New Jersey.

Robert McClure opened an office on Sycamore Street between Third and Fourth in 1792, prospering, according to Drake, because of the charm and ability of his wife rather than the excellence of the tonic bitters which he dispensed. He left Cincinnati in 1802.

From 1794 to 1804, there was a remarkable medical practitioner named Peter Smith in Columbia. According to John Uri Lloyd, Smith was the son of a doctor in New Jersey. He attended and graduated from Princeton University and began years of wandering through the South, inveighing against slavery, preaching the gospel, and healing the sick. He was a botanist, interested in the medicinal uses of herbs and roots. He became fascinated with the pharmacopoeia of the Indians, and in 1812 published "The Indian Doctor's Dispensatory." This was the first medical textbook published in Cincinnati. (Daniel Drake's "Notices of Cincinnati" published in 1810 was not a medical textbook.)

In 1797, in addition to Smith, Cincinnati's civilian doctors consisted of John Hole (who retired the following year), John Sellman, Robert McClure, and John Cranmer, who came to Cincinnati from Pittsburgh and practiced on Second Street between Main and Walnut until his death from cholera in 1832. Daniel Drake mentions a Dr. John Adams from Massachusetts, who practiced briefly but left before 1800.

"New" Doctors End Colonial Period

The Colonial Period ended early in the 19th century. The first of the "new" doctors was Dr. William Goforth. Born in 1766 in New York, too young to have played a part in the Revolution, he received his medical training in New York. In 1788, trying to obtain a body for dissection, he became involved in a riot and was forced to flee. He joined his brother-in-law, John Stites Gano, for a trip to Cincinnati. On the voyage down the



THE OHIO STATE MEDICAL JOURNAL IS A BICENTENNIAL PARTICIPANT. Ohio, he met the Isaac Drake family. Goforth then spent ten years practicing medicine in Washington, Kentucky just outside of Maysville. In 1800, he moved to Cincinnati to take over the practice and home of Richard Allison. Allison's home, called "The Peach Orchard," was just east of Fort Washington. In 1802, Goforth arranged for John Stites of New York to join him as a partner.

Stites had attended medical lectures at the University of Pennsylvania, and although he did not graduate, was considered extremely well educated. The partnership lasted for a year or two until Stites contracted tuberculosis and was forced to retire to Kentucky, where he died in 1807. Goforth was of the Brunonian school, springing from the teaching of Boerhaave, whereas Stites adhered to the medical philosophy of William Cullen and Benjamin Rush. Since Goforth hated Benjamin Rush, the patients of the two partners must have had more than a few therapeutic difficulties.

In the meantime, Richard Allison returned to practice in Cincinnati, compelling Dr. Goforth to relinquish the "Peach Orchard" home. Allison accepted Samuel Ramsay as a partner in 1808. Ramsay continued the practice long after Allison's death in 1816, when he moved the office to 14 West Front St.

Fort Washington Is Abandoned

Fort Washington was ordered abandoned in stages between 1802 and 1805. The garrison was moved across the Ohio River to Newport Barracks on the east bank of the Licking River. (Dr. Goforth moved into the quarters formerly occupied by the commandant.) What happened to the hospital at the north edge of the Fort is not known. It may still have been in use since no similar facility existed in Cincinnati, which then had some 750 inhabitants.

Owing either to the military atmosphere or perhaps to Allison's influence, Goforth became the Surgeon-General of the 1st Ohio Militia. This at least suggests that the hospital was still being used, with Goforth in charge and living a few hundred feet from it. He attached considerable importance to his official military position because he used the title in signing the diploma he bestowed on Daniel Drake in 1805.

Between 1800 and 1805, William Goforth taught and inspired the young Daniel Drake, sending him to Philadelphia to complete his medical studies. When Drake returned, Goforth made him a partner. Goforth turned his practice over to Drake when he retired and left Cincinnati in 1807, the year all the structures at Fort Washington were torn down. With Daniel Drake, there began a new era in the history of Cincinnati and Ohio medicine.



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The survey is a slightly modified version of one developed by Frederick T. Suppes, M.D., President of the Academy of Medicine of Cleveland. It was reviewed by the OSMA Committee on Public Relations.

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 noisy—
- 3) You have been given an appointment for this visit. Was your wait too long___ about right.__ Were you greeted when you came to office and told about how long you might have to wait? yes__ no__ If your wait was delayed because of a special problem or emergency of a previous patient, do you feel this is justified? yes__ no__
- 4) Did you have a problem obtaining this appointment?

 yes___ no___

 Have you been able to get an appointment for an acute illness when you called early in the morning for that same day? yes___ no___

 Was the manner in which your call was handled satisfactory and personal? yes___ no___
- 5) I have long been concerned with recording basic health data on my patients, compiling your health records in my charts, and performing blood tests, electrocardiograms and other studies to measure your general health status to help identify potential problems that might be future problems. Is this:

 OK___ great__ too much__ too expensive__ I haven't had any of these things done for me__
- 6) Did you receive adequate instruction and care in the examining room? yes___ could be better___ Did you have enough time with me to have your questions answered and your problem evaluated? yes__ no__
- 7) As much as I hate to discuss fees—here goes. Did you feel your fee for your service was: too much___ satisfactory___ should have been more__ When you call the office for a prescription or advice and the doctor reviews your chart and talks with you, should you be charged for this service? yes__ no___
 - When you submit an insurance form for services over a period of time which requires a review of your records and charges and completion of form, should you be charged a fee for this service? yes___ no__
- 8) Were you advised of my diagnosis, treatment and anticipated results of the treatment? yes____ no___
- 9) The results of this little questionnaire will be helpful to me, but how was it for you? OK, I'll answer others... Ugh, don't do it again...
- 10) Your comments or suggestions. Thank you for your interest and time. I will look forward to your direction from this questionnaire. Please fold and drop in the box in the waiting room.



Following are names of new members of the Ohio State Medical Association certified to the headquarters office during August, 1975. List shows name of physician. county, and city in which he is practicing, or in which he is taking postgraduate work.

Butler (Fairfield) Joseph C. Yu

Cuvahoga (Cleveland) John Clement Baker Paul Alexander Cline Warren Go Cua Linda C. Cunanan Mihir Kanti Datta Yalcin Dincman Bina K. Erasmus Richard Alan Friedell Richard Eugene Holzheimer Kannampilly L. Jacob Fereydun M. Mansubi Thekkumpurath J. Maximin Samir Y. Mourad Jacqueline A. Rogers Coleman Robert Sachs Thomas Eades Shaw Martha Mae Snearly Alexander Sydoriak Israel Oscar Weissman John Donald Zachary

Darke (Greenville) Hvun Young Park

Erie (Huron) Michael Dale Holmes

Favette (Washington C.H.) Kooi-Wham Chan

Hamilton (Cincinnati) Kenneth Gordon Amend Samuel H. Baird Billy Oral Barclay David Victor Berkowitz Gregory Greene Boren Terrence James Carrigan Robert Alan Clark David W. Drennen Judith Lynne Folkema David Grant Gilbert Victor Philip Glassman Clifford G. Grulee, III Byron William Gustin

Hamilton (cont.) Peter Lynd Heiman Bernard Lee Hertzman Jennifer Jean Johnson Ierald Kav Herbert D. Long, Jr. Martin L. McTighe Shakil Mohammed John Brockway Noll Yuet Mei Ooi Richard Douglas Reidel Donald A. Saelinger Abbas Shariat Steven Arthur Spreen

Licking (Newark) Choong Won Suh

Lucas (Toledo) Mounir Badih Elkhatib Thomas George Sherman Mahoning (Youngstown) Ragu R. Sambandham

Marion (Marion) Arturo Hernandez-Recio

Montgomery (Dayton except where noted) Narayana V. Kandula Anthony F. Lugo Chester Kelley Robinson Vandalia Carol Jeanne G. Ryan Kettering Rolando S. Sineneng Lee Steinfurth

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Industrial Audiometry & Conservation Of Hearing; Oct. 22-24; Stouffer's University Inn, 3025 Olentangy River Rd., Columbus: Contact: Center for Continuing Medical Education, A352 Starling Loving Hall, 320 W. 10th Ave., Columbus 43210; \$140 registration fee.

Dermatology For The Dermatopathologist And Pathologist; Oct. 23; Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; Acceptable for category 1 credit toward AMA Physician's Recognition Award.

Medical Malpractice And The Law; Oct. 24; Ohio Northern University College of Law, Law Review Editor, Ada, Ohio 45810; \$40 registration fee.

Reconstructive Surgery Of The Knee; Oct. 29-30; Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; Acceptable for category 1 credit toward AMA Physician's Recognition Award.

Ear, Nose & Throat And The Practicing Physician; Oct. 29; Office of Continuing Education, Case Western Reserve University, 2109 Adelbert Rd., Cleveland 44106; Acceptable for 61/4 prescribed hours by American Academy of Family Physicians and category II credit toward AMA Physician's Recognition Award; Application made for category 1 credit; \$55 registration

Tri-State Orthopaedic Society; Oct. 30-Nov. 1; Fawcett Center for Tomorrow, 2400 Olentangy River Rd., Columbus; Contact: Center for Continuing Education, A352 Starling Loving Hall, 320 W. 10th Ave., Columbus 43210.

Peripheral Vascular Disease Symposium: Oct. 31-Nov. 1; Stouffer's University Inn, 3025 Olentangy River Rd., Columbus; Contact: Center for Continuing Medical Education, A352 Starling Loving Hall, 320 W. 10th Ave., Columbus 43210; \$60 registration fee.

Rehabilitation of the Alcoholic; Nov. 11; Fort Steuben Academy of Medicine, 525 N. Fourth St., Steubenville 43952.

Clinical Problems in Gastroenterology; Nov. 12-13; Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; Acceptable for category 1 credit toward AMA Psysician's Recognition Award.

Clinical Problems In Gastroenterology; Nov. 12-13; Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; Acceptable for category 1 credit toward AMA Physician's Recognition Award.

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What's New In Pediatrics; Nov. 12; Case Western Reserve University: Contact: S. S. Strassman, M.D., Pediatric Dept., Rainbow Babies and Childrens Hospital, University Circle, Cleveland 44106.

eveland 44106.

The Critically Injured Patient: Emergency Surgical and Medical Care; November 13, 14, & 15; the Marriott Inn, Cleveland, O. Sponsored by the American College of Surgeons Committee on Trauma and the Department of Surgery, Case Western Reserve Medical School, Cleveland. Fee is \$150 for physicians and \$50 for interns and residents. Contact: the ACS Trauma Division, 55 Erie St., Chicago, Illinois 60611, or Dr. Mark A. Mandel, University Hospitals of Cleveland, 2065 Adelbert Rd., Cleveland, Ohio 44105. Approved for 20 hours of AMA Category 1 credit and 20 hours accreditation of the American Academy of Family Practice.

Contact Lens Seminar; Nov. 13-15; Fawcett Center for Tomorrow, 2400 Olentangy River Rd., Columbus; Contact: Center for Continuing Medical Education, A352 Starling Loving Hall, 320 W. 10th Ave., Columbus 43210.

The Critically Injured Patient: Emergency, Surgical and Medical Care; Nov. 13-15; Marriott Inn, 4277 W. 150th St., Cleveland; Contact: Mark A. Mandel, M.D., University Hospitals of Cleveland, Dept. of Surgery, 2065 Adelbert Rd., Cleveland 44106; Fee is \$150 for physicians, \$50 for nurses and house officers.

Perspectives in Ophthalmology; Dec. 3-4; Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; Acceptable for category 1 credit toward AMA Physician's Recognition Award.

Urology X-Ray Seminar; Dec. 7-9; Stouffer's Cincinnati Inn; Contact: Arthur T. Evans, M.D., Div. of Urology, University of Cincinnati Medical Center, 231 Bethesda Ave., Cincinnati 45267.

Ohio Medical Education Network

Starting this month, medical staff members at 71 hospitals in the United States and Canada will participate in the 1975-76 season of the Ohio Medical Education Network (OMEN.) The continuing education needs of Ohio physicians have been served by OMEN's unique two-way network for 13 years.

Through use of microphones and telephones linked to amplifiers and loudspeakers at participating hospitals, OMEN's weekly programs allow the exchange of ideas and experiences among practicing physicians in widely separated locations. The first half of each program consists of a formal lecture/slide presentation. The second 30 minutes is a discussion period in which panelists respond to questions and comments from physicians at the various hospitals.

The panelists are medical educators from Ohio's four medical schools: The Ohio State University, Case Western Reserve University, The University of Cincinnati, and the Medical College at Toledo. The closed-circuit nature of the discussions assures professional privacy and frequently fosters lively dialogues.

Moderator for the "live" programs is Robert B. Schweikart, Ph.D., Director of the Center for Continuing Medical Education at The Ohio State University's College of Medicine. He has been associated with OMEN since its inception in 1962.

(Continued on page 737)



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(continued)

The OMEN programs are accredited by the OSMA and the AMA. Thus, OMEN minimizes the physician's need to engage in extensive, expensive, and/or time-consuming travel. The programs are held Monday through Friday from 12:00 Noon to 1:00 PM, Ohio time, from October through mid-April.

As a service to OSMA members, a schedule of OMEN programs will be published each month in The

Journal:

Concepts of Diarrhea, Oct. 13-17.

Oral Lesions-Cancer Or Not?, Oct. 20-24.

The Renin-Angiotensin Story—Its Practical Application, Oct. 27-31.

Congenital Biliary Atresia: Diagnosis & Management, Nov. 3-7.

Cancer of the Bladder, Nov. 10-14.

Pulmonary Function Tests, Nov. 17-21.

OUTSIDE OHIO

Contemporary Internal Medicine; Oct. 20-24; Co-sponsored by Cornell University Medical College, New York, N.Y.; Contact: Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

Liver Disease and the Internist; Nov. 2-3; Ambassador Hotels, Chicago, Ill.; Contact: Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

Central Nervous System in the Newborn; Nov. 13-14; University of Louisville School of Medicine; Contact: Dr. B. F. Andrews, 200 E. Chestnut, Dept. of Pediatrics, Louisville, Kv. 40202.

Clinical Application of Intra-Aortic Balloon Pump; Nov. 14-15; Americana Hotel, Bal Harbour, Fla.; Contact: Div. of Continuing Medical Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex; Miami, Fla. 33152.

Cardiovascular and Pulmonary Function in Ischemic Heart Disease; Dec. 3-5; Americana Hotel, San Juan, Puerto Rico; Acceptable for 12 hours credit toward AMA Physician's Recognition Award; Contact: Dale E. Braddy, Director, Continuing Education, American College of Chest Physicians, 911 Busse Highway, Park Ridge, Ill. 60068; Fee is \$125 for ACCP members, \$150 for nonmembers, and \$75 for residents, nurses, and therapists.

First Mid-Winter Virgin Islands Clinical Conference; Jan. 29-31, 1976; Acceptable for 14 hours of category 1 credit toward AMA Physician's Recognition Award; Contact (airmail): Harold A. Hanno, M.D., U.S. Virgin Islands Medical Society, Box 1442, St. Thomas, Virgin Islands 00801.

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"Project Bank." Sound intriguing? It is a terrific new idea promoted by the AMA Auxiliary. This does not mean any change in the objectives and programs of auxiliary. Only the means of exchanging ideas and reporting results is being changed. Priorities will be determined at the county level as service projects are promoted to meet community needs.

The Project Bank is like any other bank—a place for deposits and a place for withdrawals. In other words, it is a place from which county auxiliaries for their own successful programs of other auxiliaries for their own use and, at the same time, it serves as a place to which these auxiliaries can send their own successful programs for others to use.

The new program has been set up in this fashion: There are three different special catalogues. The one catalogue is for state use, giving a brief description of the projects and programs. The state coordinators (Mrs. Emil Barrows and Mrs. Armin Melior) will have the responsibility of getting this catalogue to the county auxiliaries requesting it. The second catalogue is for the national area coordinators (North Central-Mrs. Louis Loria of Ohio) giving a more detailed description of these projects and programs. They in turn will funnel the further detailed descriptions upon request to state coordinators or county auxiliaries. The third catalogue will be at National Auxiliary headquarters in Chicago which will

contain full details as well as materials used in the projects or programs.

The Project Bank offers 15 different areas of activity from which to choose: Aging, Blood Donor, Children and Youth, International Health, Screening, Venereal Disease, Family Life, Fund Raising, Health Careers, Health Education, Mental Health, Safety, Drug Abuse, Package Programs and Resource Listing.

Here are the county auxiliary's guidelines for "drawing" from the Project Bank: determine the needs of the individual community; write for the catalogue; write to the state coordinator or Central Office for help in selecting an appropriate program; if more detailed information is desired, contact the area coordinator; if a county desires ideas for a specific area, write to the state coordinator for suggestions; once a county auxiliary has made a definite decision about the program or project, write directly to the National Project Bank in Chicago, using the standard information request form provided by National.

Here are further guidelines for submitting (on the part of the county auxiliary) one of your own programs or projects to the Project Bank: there is a special Project Bank catalogue sheet that must be filled out (it is available from the state coordinator or Central Office). It is very important to put in all the pertinent information (Continued on page 744)



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Auxiliary/continued

that could be helpful to other counties wishing to use that program. The auxiliary must send all the material to Central Office in Columbus where copies will be made for Ohio's files and the original will then be sent on to Chicago. At National headquarters, the program will be evaluated and put into the Project Bank.

It was John Ruskin who wrote: "He is the greatest artist who has embodied, in the sum of his works, the greatest number of the greatest ideas." I don't think I'm straying too far afield by seeing in the auxiliary and its Project Bank a degree of artistry that similarly will embody "the greatest number of the greatest ideas"—this time on behalf of the medical profession.

Immunization Month The U.S. Center for Disease Control has scheduled the third annual Immunization Action Month for October, 1975. Once again the Ohio State Department of Health and the Ohio State Medical Association are working together to insure the immunization of unprotected 1-to-4-year-olds. (Unbelievably, there are some five million children in that age category over the United States who are still immunized inadequately or not at all.) The OSMA is alerting physicians themselves through official publications. The county auxiliaries are asked to assist in alerting the public in cooperation with their county medical societies, as well as local health departments. It is nothing short of incredible that in this day and age, any parent anywhere would have to be urged to protect the pre-schooler from such preventable diseases as polio, rubeola, rubella and other contagious diseases. The county auxiliary can perform a valuable service by providing some of the action of Immunization Action Month. A Tribute-Mrs. Fred Hapke

Not too many months ago, Franklin County Auxiliary lost its new president, Betty Anderson Hapke. In the September issue of "Jottings," Franklin County's monthly newsletter, there is a beautiful tribute to Mrs. Hapke

written by Mrs. J. Hutchison Williams. (Dr. Williams is the councilor for OSMA's Tenth District.) It is fitting that this tribute be repeated here, for Betty Hapke was a dedicated auxilian and an outstanding member:

"The Franklin County Auxiliary lost not just a President but a warm, loving friend Betty Anderson Hapke was an individual who cared and shared with her family and her friends and her community. A graduate nurse, she worked with her husband in his office. The Camp Fire Girls, the Starling-Ohio Women's Club, the Women's Association of the Columbus Symphony and, of course, the Franklin County Auxiliary have been enriched by her presence.

"Betty is survived by her husband, Dr. Fred Hapke, an obstetrician and gynecologist, and two children, Allison Beth and David Bartel, as well as her parents, Mr. and Mrs. A. B. Anderson of Zanesville. A victim of multiple sclerosis, Betty Hapke never allowed her limitations to overwhelm her. Rather she gave those talents she possessed to family and community. Those of us privileged to know her feel the loss keenly. Yet we salute her with pride and honor. To the family, we extend our sympathy and love." As does the Ohio State Medical Association Auxiliary.

Attention—County Auxiliaries!

Where are your newsletters, your newspaper clippings, your typewritten accounts of outstanding activities? Believe it or not, this column has to be "fed" once a month and you'd be surprised at how quickly each month comes around! So please keep me informed. Also, every other month, this reporter is writing up an outstanding auxiliary activity for "Your Doctor Reports," the new tabloid newspaper sent out monthly by OSMA for the physicians' waiting rooms. This is a wonderful opportunity to communicate with the public. Remember that "good, the more communicated, more abundant grows!"



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obituaries

James L. Curtin, M.D., Fremont; University of Michigan Medical School, 1922; age 74; died July 29; member of OSMA and AMA.

Anthony A. Gavey, M.D., Springfield; University of Cincinnati College of Medicine, 1929; age 82; died August 28; member of OSMA and AMA.

Laurence A. Kater, M.D., Woodmere; Michigan State University Medical School, 1972; age 28; died August 22.

William H. Kauffman, M.D., Willard, formerly of Columbus; Wayne State University School of Medicine, 1939; age 63; died July 31; member of OSMA and AMA.

Sidney W. King, M.D., Cleveland; Case Western Reserve University School of Medicine, 1941; age 58; died August 6; member of OSMA and AMA.

Manuel Moreno, M.D., Akron; National University of Columbia, 1954; age 46; died August 16; member of OSMA and AMA.

Richard J. Sekera, D.O., London, Ohio; Chicago College of Osteopathy, 1964; age 42; died August 11; member of OSMA and AMA.

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In This Issue:

The Brown Pharmaceutical
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Burroughs Wellcome Co718
Capital Financial Services
Daniels-Head745
Dorsey Laboratories, Div. of Sandoz-Wander, Inc
Flint Laboratories, Div of Travenol Lab., Inc699-702, 740, 741
Geigy Pharmaceuticals687, 688
Harding Hospital742
International Travel Advisors, Inc710
Landmark Medical Buildings743
Lilly, Eli and Company694
The Medical Protective Company738
Menendian, K.A. Carpets745
Merck, Sharp & Dohme, Div. of Merck & Co., Inc

Ortho Pharmaceutical Corp734-736
The Park Plaza Hotel725
Pharmaceutical Manufacturers Association
Robins, A. H. Company689-691
Roche Laboratories, Div. of Hoffman- LaRoche, IncInside Front Cover, 681, Inside Back Cover, Back Cover
Roerig & Co., Div. of Pfizer727
Schmidt's Sausage Haus744
Searle Laboratories, Div. of G. D. Searle & Co
SK&F Co., Subsidiary of Smith, Kline & French Laboratories
Sperry Remington Office Systems739
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NO. 16



Clinical and Scientific Articles

NONSURGICAL REMOVAL OF RETAINED COMMON BILE DUCT STONES IN OUTPATIENTS Michael Van Aman, M.D., and William Molnar M.D., Columbus	765
THE VALUE OF ELECTROMYOGRAPHY IN LUMBAR DISC LESIONS Ian C. MacLean, M.D., and Paul H. Curtiss, Jr., M.D., Columbus	769
EMERGENCY MANAGEMENT OF OCULAR INJURIES William H. Havener, M.D., and Torrence A. Makley, Jr., M.D.	776

Special Articles

FOR THE YEAR ENDED DEC. 31, 1974	791
FPIDEMICS IN FARLY OHIO	798

Features

News	756	Woman's Auxiliary	820
Comments	763	Continuing Education	796
Ohio Health News	784	Obituaries	814
Council Minutes	807	Journal Advertisers	822
New Members	819	Classified Ads	823

COVER: The Ohio Historical Society provided this drawing of the courthouse and jail at Marietta, Ohio. The structure was built in 1798.

Cincinnati Physician Elected Officer Of Neurological Assn.

John M. Tew, Jr., M.D., of Cincinnati, was recently elected Secretary-Treasurer of the Section of Cerebrovascular Surgery of the American Association of Neurological Surgeons. This division's goal is to reduce the incidence of disability and death due to cerebral vascular disease by educating physicians in the diagnosis and treatment of individuals prone to such illness.

Dr. Tew also holds positions as Associate Director of the Neurosurgical Training Program at Good Samaritan and Christ Hospitals, Chairman of the Section of Neurosurgery at Deaconess Hospital, and President of the Board of Trustees of the Ohio Division of the American

Trauma Society.



John M. Tew, Jr., M.D.

For Physicians' Ears Only, Medical News Through Radio

New radio stations in Cincinnati and Cleveland will allow physicians in those areas to receive the latest news about advances and developments in medicine almost as soon as the first public announcement is made, and often, from the scientist making the news.

The radio stations are part of the country's newest radio network, Physicians Radio Network (PRN). PRN has been broadcasting news specifically for physicians for the past year and is rapidly expanding to large cities throughout the country. Material for the broadcast is prepared by over 100 radio news correspondents who

regularly cover medical meetings and conferences.

In Cincinnati, the PRN-affiliated radio station broadcasts on a subsidiary frequency of WSAI-FM (formerly WJDJ). A special radio receiver is needed since the radio station cannot be received with a normal AM-FM receiver. PRN will provide a receiver, free of charge, to any Cincinnati or Cleveland area physician desiring one. Physicians may obtain receivers by writing to: Physicians Radio Network, #15 Columbus Circle, New York, New York 10023.

"The average physician is inundated with magazines, professional literature, and information about new products, usually to the point where it is hard to keep up with them," said Jay Raeben, president of Visual Information Systems, which established PRN. "We see our network as a way for the busy physician to keep up with the latest developments in his particular field of interest."

PRN's broadcast day is divided into hour-long programs, with segments of each hour assigned to various aspects and specialities of medical practice. While most of the hour is devoted to news from national medical centers and scientific meetings, some of it will include news and information from Ohio.

Grant Hospital Publishes Infection Control Guide

Grant Hospital, Columbus, has released a practical infection control guide which hospitals and other institutions can use to build infection control programs and policies. Common Sense Infection Control was written for physicians on infection control committees, nurse epidemiologists and other health care personnel.

Major contributors to the book include Pauline Mc-Hugh, R.N., Nurse Epidemiologist, Brooks Hurd, M.D., Director of Laboratories, and Harry Topolosky, M.D., Chairman of the Infection Control Committee, all at Grant Hospital. Kathryn Wenzel Owens, R.N., Infection Control Nurse at Stanford University Medical Center, and Dorothy Branson, Ph.D., Microbiologist at Grant,

reviewed the completed manuscript.

The book, available to health care institutions at a price covering its manufacturing costs, is \$20 per copy, with \$1 per order for handling and mailing. Orders from Ohio should include 4 percent sales tax or the tax-exempt number of the institution. Orders should be directed to Grant Hospital Research and Education Foundation, c/o Development Department, 309 East State Street, Columbus, Ohio 43215.

Miss Wheelchair America Is Crowned in Columbus

Dixie Lee Ethridge of Mississippi was crowned 1976 Miss Wheelchair America at the fourth annual pageant held September 26-28 in Columbus. Miss Ethridge, a quadriplegic having suffered polio at age 11 months, is currently a graduate student in English at Delta State University. Mississippi.

All contestants were judged in the areas of achievement after the accident or illness, poise and ability, and appearance at the pageant which promotes public awareness of the disabled. Miss Ethridge will make many appearances on behalf of the pageant including an initial one at the meeting of the American Academy of Physical Medicine and Rehabilitation in Atlanta.

Thirty-five candidates vied for the title with Shirley Roden Holmes of Illinois being named first runner-up. Mrs. Holmes holds a masters degree and is a resource special education teacher in Carbondale Public School District 95. She received a \$500 scholarship. The winner received a \$2000 scholarship; and Everest and Jennings, a wheelchair manufacturer, gave her the wheelchair of her choice.



Pageant co-ordinator was William E. Ebert, Executive Secretary of the Ohio Governor's Committee on Employment of the Handicapped. The president of the pageant was Ernest W. Johnson, M.D., Professor and Chairman of the Department of Physical Medicine at The Ohio State University College of Medicine.

Pageant judges included people familiar with the handicapped: James A. Bailey, M.D., Clinical Assistant Professor in the Department of Physical Medicine at Emory University and himself a paraplegic; Mrs. Mary Barnes, a former model now a rehabilitation patient havhad polio at 41; Alicia Hastings, M.D., Professor and Chairman of the Department of Physical Medicine at Howard University; Marian Lucas, Director of the Physical Therapy Department at Community Hospital in Springfield, Ohio; George Conn, member of HEW's Rehabilitation Services Commission and himself a paraplegic; and Larry Volin, Deputy Director in the State Relations Office of the President's Committee on Employment of the Handicapped.

AMA Membership Hits An All-Time High

The American Medical Association reports that its total dues-paying membership reached an all-time high in August — 173,221 paid physician members. The membership rolls reflected an increase of about 6,100 over mid-August 1974 figures, marking the second year in a row in which a record membership has been recorded. An additional 36,000 non-dues-paying members, including physicians on military leave, in the U.S. Public Health Service or on retirement status, raises the total membership to in excess of 209,000.

The most dramatic membership gains in 1975 were among interns, residents and medical students with more than a 50 percent increase realized in both the combined intern and resident category and the medical student group. Figures issued in mid-August indicate 7,897 interns and residents are AMA members, an increase of 2,800 over the 1974 total. At the same time medical student membership rolls reflect a total of 7,467 compared to the 1974 total of 4,713.

James H. Sammons, M.D., Executive Vice-President of the American Medical Association, noted that the membership rise indicates "physicians clearly support the concept of a single strong organization representing their views and assuming a leadership role in medical and health affairs."



Bureau of Workmen's Compensation Announces

New Billing Procedure Solves Doctors' Bookkeeping Problem

A major bookkeeping problem of many physicians can be solved by a new billing code reference procedure recently adopted by the Bureau of Workmen's Compensation (BWC). The new procedure enables physicians to promptly identify specific fee bills being paid by the Bureau, and to properly credit the payments to the patient account.

In the past, the physician would receive the Bureau's warrant with a remittance advice form that indicated only the total of each patient's medical benefit being paid by the Bureau. If the physician filed several fee bills on behalf of a patient or if portions of a fee bill were disallowed, the physician faced the horrendous task of matching BWC payments with fee bills. Often, it was nearly impossible to determine which fee bills were paid.

The Bureau's new billing reference code permits each physician to code his or her bills. This code then appears on the remittance advice form so that the specific fee bills being paid are clearly identified.

The physician's proper use of the reference code is vital to the success of the program. Here are some guidelines:

•The reference code should be placed to the left of the physician's signature. An arrow should precede the number to clearly identify it as the reference code. (See example.)

The code may be any number you choose that provides a reference to the specific fee bill. Most physicians will use the date of billing or date of last service

•The code should contain not more than six digits. Also, it should contain numbers only—no alphabetical or special characters.

When you receive the Bureau's remittance advice form, it will print your reference code in the column headed "date of billing" with the amount being paid for that fee bill. The patient's name and his BWC claim number also are printed on the remittance advice form as an additional bookkeeping aid.

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comments

Regional Plastic Surgeons

At a time when federal agencies and hospitals are especially concerned with definitions, privileges, and capabilities, it behooves an enlightened medical profession to reflect on who's who in the growing field of plastic surgery. We tend to rely on semantics and impressions. If plastic surgery is needed, we may turn to a plastic surgeon because he is a specialist. That tendency is fine, but in following it, we fail to recognize the many practitioners of plastic surgery who do not use the title "plastic surgeon."

Basically, plastic surgery is both a method and a medical specialty. In effect, the plastic surgeon is a specialist in the method. He is obviously a practitioner of plastic surgery, is certified by the American Board of Plastic Surgery, and is officially designated a plastic surgeon. There is virtually no chance of anyone misunder-

standing his scope of medical practice.

Who, then, are the other practitioners of plastic surgery? They are specialists in a particular region or organ of the body, for example, ophthalmologists, who after certification by the medical board in their specialty, subspecialize in plastic and reconstructive surgery. Thus, during their specialty training, they master both the specialty region and the method of ophthalmic plastic surgery. Some of these specialists have become known as

regional plastic surgeons.

Unlike general plastic surgeons, regional plastic surgeons do not present a consistent identity pattern. Some otolaryngologists may practice under the title "head and neck plastic surgeon" or "cosmetic facial surgeon." Other regional specialists may add the term "plastic surgeon" to their specialty title, for example, the ophthalmic plastic surgeon and the dermatologic plastic surgeon. Still others, such as orthopedists, obstetrician-gynecologists, urologists, neurosurgeons, colon and rectal surgeons, and general surgeons, do not usually add the term "plastic" to their specialty title, although they may use plastic and reconstructive surgical techniques.

A leading ophthalmic plastic surgeon estimates that 1,000 ophthalmologists do a significant amount of plastic and reconstructive surgery. The chief of one otolaryn-

gology residency training program estimates that 4,000 otolaryngologists perform regional plastic and reconstructive surgery. A prominent dermatologist estimates that 300 members of his specialty practice plastic surgery.

About 180 maxillofacial surgeons spend all their time doing plastic and reconstructive surgery. Virtually all of the neurosurgeons, estimated at 2,000, perform cranioplastics for skull defects. Most of the 9,200 orthopedists practice plastic and reconstructive surgery, because that in the broadest sense is the nature of their work. Many of the 6,000 urologists do some plastic reconstructive surgery in their specialty area, as do many of the 30,000 general surgeons who apply plastic techniques in pairing hernias, strengthening the abdominal wall, removing tumors and ulcers, working with or operating burn units, and repairing defects with skin grafts.

Conservative estimates from the most pertinent medical specialties suggest that about 22,000 American physicians practice regional plastic surgery. Of that total, more than 7,000 perform plastic and reconstructive surgery in the head and neck area alone. The significance of these numbers is seen when they are compared with the number of specialists, an estimated 1,500, who are designated to the service of the service of the service of specialists, an estimated 1,500, who are designated to the service of the ser

nated plastic surgeons.

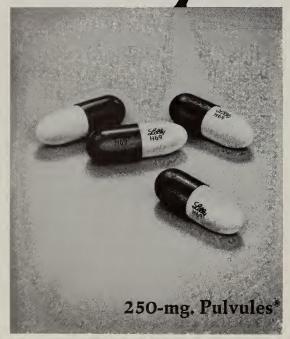
Obviously, no medical specialty has the exclusive capability to perform plastic and reconstructive surgery. No board certification by any specialty and no medical title can guarantee a fine surgical result. In discussing plastic surgery with our patients, we might well remember that there are good, fair, and poor surgeons in all specialties. The most important consideration, therefore, is not the surgeon's title but his ability as manifested by his results.

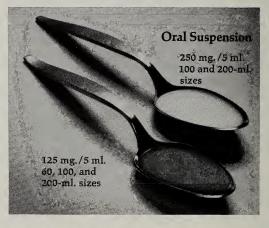
Trent W. Smith, M.D. Columbus, Ohio

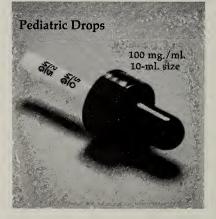
Dr. Smith is the Immediate Past President of the American Academy of Facial Plastic and Reconstructive Surgery, Inc.

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Nonsurgical Removal of Retained Common Bile Duct Stones in Outpatients

Michael Van Aman, M.D. William Molnar, M.D.

Successful percutaneous extraction of retained bile duct stones was performed on three outpatients with-out significant morbidity. The extractions were per-formed through the tract left by an indwelling T-tube using a Dormia stone basket. The advantages of an outpatient percutaneous procedure over secondary bile duct surgery are apparent.

THE PROBLEM OF RETAINED bile duct stones after cholecystectomy is a relatively common one; it is estimated that, even with operative cholangiography, retained stones occur in approximately 3 to 5 percent of all patients operated on for gallstones. 1,2 The incidence of retained stones is even higher (8 to 9 percent) in patients who underwent choledocholithotomy at the time of initial surgery. 1 A second operative procedure on the biliary tree for extraction of retained stones represents a significant problem. Exploration of the common bile duct for biliary calculi is associated with a mortality rate of 2.5 to 4.3 percent.^{3,4} The average hospitalization for such sur-

gery is 10 to 14 days and associated potential complications include common bile duct stricture, pancreatitis, sepsis, and subhepatic abscess formation.⁵ The use of several solvents including chenodeoxycholic acid by mouth and heparin instilled through the T-tube has been tried with variable success. There is no current way to predict which stones will dissolve. In addition, such methods sometimes take as long as six months even when successful.

In the last four years, successful percutaneous extraction of retained biliary stones has been performed with increasing frequency. It is our purpose to review the technic and to describe three cases in which successful stone extraction was performed on an outpatient basis.

Technic

Standard technics with slight technical variation have been described in several previous papers. 6-8 Our technic will be briefly reviewed here. The postoperative demonstration of retained stones usually is made by T-tube cholangiography within 10 to 18 days of the initial surgery. If stones are demonstrated at that time, the percutaneous extraction is delayed for four to six weeks postoperatively to allow a firm fibrous tract to form around the T-tube. A T-tube cholangiogram is then performed to confirm the presence of a retained stone and to demonstrate the anatomy of the biliary tree. If proteinaceous debris is demonstrated on the cholangiogram, saline lavage via the T-tube is performed until clear bile is returned. The patient then is premedicated with meperidine hydrochloride. A guide wire with flexible tip is passed through the T-tube into the bile duct and the T-tube is removed. Subsequently, a soft rubber catheter of appropriate diameter for the size of the fistulous tract is inserted over the guide wire past the retained stone. The guide wire is then exchanged for a

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Submitted March 5, 1975.

Dormia stone-retrieval basket. This is a basket-shaped wire instrument originally described for the retrieval of ureteral stones. This basket is compressible and can be afterloaded into catheters as small as a #6 French. It springs open when advanced beyond the tip of the catheter, thus allowing the stone to be trapped within it either by a push-pull motion or by rotation. The basket is never allowed to advance in the bile duct without being encased in the catheter. The catheter then is used to tighten the basket about the stone; the stone, Dormia basket, and catheter are removed in one motion. This procedure is summarized in Figure I.

Case Presentations

Case 1. — A 29-year-old white man was seen approximately five weeks postcholecystectomy with T-tube cholangiographic evidence of a filling defect in one of the major radicles of the right hepatic bile duct (Fig. 2A). His problem was complicated both by the intrahepatic position of the stone and by the fact that both limbs of the T-tube were directed distally in the common duct. After careful instruction, initial attempts at dissolving the stone by infusion of cholic acid through the T-tube performed by the patient at home were only partially successful. After two weeks, there was a slight decrease in size of the stone, however, no additional shrinkage took place over the following four weeks. Consequently, percutaneous stone removal was undertaken.

A guide wire with a flexible tip was passed through the T-tube into the distal common bile duct and the T-tube was removed. The guide wire then was used to manipulate the stone into the distal common bile duct where catheter and basket extraction were performed without difficulty. A repeat cholangiogram after the procedure showed no evidence of retained stones (Fig. 2B). The patient suffered mild, transient nausea, but had no other symptoms. He was allowed to return home on the same day, after three hours of observation. Follow-up contact with the patient revealed complete cessation of bile flow from the cutaneous tract in approximately eight hours with no further symptoms.

Case 2. — This patient was a 32-year-old white woman who was seen eight weeks postcholecystectomy with T-tube cholangiographic evidence of an 8-mm retained stone in the

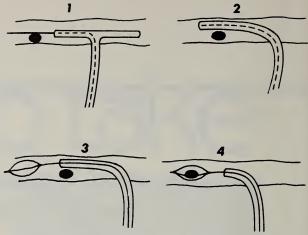


Fig. 1. Procedure for percuaneous extraction of retained common bile duct stone: (1) Guide wire with flexible tip is passed through T-tube into common bile duct with tip of wire past retained stone. (2) T-tube is withdrawn and soft catheter advanced over guide wire and past retained stone. (3) Guide wire is exchanged for Dormia basket and catheter withdrawn to allow basket to open within common bile duct. (4) Basket is manipulated to engage the stone within its lumen. Stone, stone basket, and catheter are withdrawn in one motion.

distal common bile duct (Fig. 3A). A guide wire with a flexible tip was inserted through the T-tube into the distal common duct and the T-tube was removed. Because of the location of the retained stone, it was necessary to pass the guide wire into the ampullary portion of the common duct and to advance the catheter partially into the sphincter of Oddi. The extraction then was performed; however, a postextraction cholangiogram showed transient spasm of the ampullary portion of the common bile duct. The patient complained of moderately severe discomfort during the injection of contrast material when the

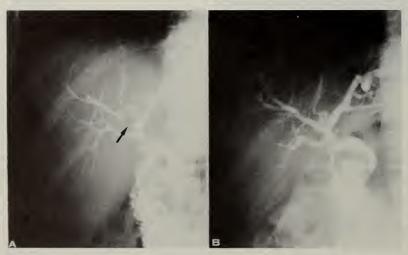


Fig. 2. (case 2) Preextraction T-tube cholangiogram showing retained stone in a major radicle of right hepatic bile duct (A), and postextraction cholangiogram demonstrating normal biliary tree (B).

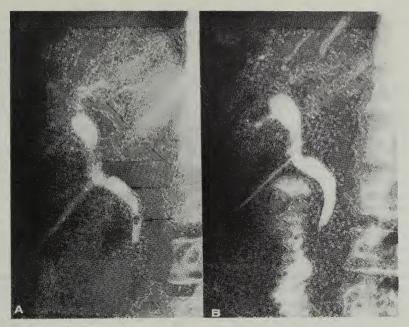


Fig. 3. (case 2) T-tube cholangiogram showing retained stone in distal common bile duct (A), and postextraction cholangiogram demonstrating normal biliary tree (B).

spasm was fluoroscopically demonstrable. After approximately 45 minutes of observation, the ampullary portion of the duct relaxed and contrast material flowed freely into the duodenum. A cholangiogram at that time showed a normal biliary tree (Fig. 3B). The patient was kept under observation for approximately two hours and allowed to return home on the same day. Follow-up contact with the patient revealed prompt cessation of bile flow from the T-tube tract with no further symptoms.

Case 3. — The patient was a 67-year-old white man who was seen approximately eight weeks after cholecystectomy with

complaints of recurrent copious bile flow through the T-tube. A T-tube cholangiogram revealed a 6-mm filling defect in the distal common bile duct (Fig. 4A). There also was mild tortuosity to the T-tube tract best demonstrated on (Fig. 4B). The T-tube was exchanged for a soft rubber catheter as previously described and stone extraction was performed with the Dormia basket without difficulty. A postextraction cholangiogram with the soft rubber catheter in place demonstrated a normal biliary tree without evidence of retained stones (Fig. 4B). The patient was allowed to return home after approximately one hour of observation. Bile flow through the T-tube tract stopped

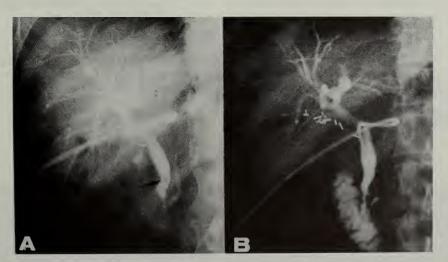


Fig. 4. (case 3) Preliminary T-tube cholangiogram revealing small stone in distal common bile duct (A), and postextraction cholangiogram showing normal biliary tree. Note mild tortuosity of T-tube tract (B).

within 12 hours, and the patient has experienced no further symptoms.

Discussion

The most recent published report describes successful percutaneous common bile duct stone removal by the use of this technic in 96 percent of a series of 126 patients.6 This procedure has been performed successfully with multiple retained stones by recatheterization of the fistulous tract after each stone removal. The complication rate in the most recent large series was less than 5 percent.6 All of the reported complications have responded to conservative therapy with no operative intervention and no permanent sequelae. There has been no reported mortality. The reported complications include bile duct perforation with consequent bile peritonitis, formation of false passages from the T-tube tract, shock induced by vagal reflex after instrumentation of the ampullary portion of the common bile duct, and transient septicemia. The procedure is performed in our laboratory with an intravenous line in place and with electrocardiographic monitoring to detect any vagally mediated hypotensive episodes. The procedure is best performed by someone familiar with angiographic technic in that the procedure is facilitated by experience with catheter and guide-wire manipulation. Almost all of the potential complications can be avoided by strict adherence to several basic principles. The initial instrumentation of the bile duct should be performed with a guide wire with a flexible tip as the lead instrument. It also is possible to use a soft steerable catheter. Neither the Dormia basket nor a stiff catheter should be advanced in the common bile duct without controlled guidance under fluoroscopic observation. Again, familiarity with this type of equipment is a prerequisite.

There are circumstances under which retained biliary stones cannot be removed by this technic. These include large stones (usually those over 1 cm in size which will not pass through the fistulous tract), stones in small intrahepatic radicles or in cystic duct remnants

which cannot be engaged with the retrieval basket, and stones distal to a surgical bile duct stricture. Other potentially compromising factors include an extremely tortuous T-tube tract or a T-tube tract too small to allow successful manipulation. For this reason, it is suggested that a #14 or larger T-tube be left in place whenever the possibility of retained common bile duct stones is entertained. This is especially pertinent when common bile duct exploration has shown stones to be present at the time of surgery.

The total time involved in each one of these procedures was approximately three hours. A large percentage of this time was involved with the technical aspects of the equipment and with postextraction observation rather than with actual fluoroscopy and manipulation in the common bile duct. These patients required no in-hospital stay and had no morbidity. The low morbidity and low potential mortality of this procedure in comparison to secondary bile duct surgery is very impressive. When one considers the current cost of hospitalization, percutaneous extraction also clearly has a marked economic advantage for the patient.

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The Value of Electromyography in Lumbar Disc Lesions

Ian C. MacLean, M.D. Paul H. Curtiss. Jr., M.D.

Some basic concepts of electromyography (EMG) are presented and the significance of the technique is discussed in relation to lumbosacral nerve root compromise. Its value is also shown as a procedure separate from and in addition to myelography. A series of 93 patients are analyzed, all of whom had lumbar disc surgery over a five-year period at The Ohio State University Hospitals subsequent to undergoing both EMG and myelography.

THERE IS CONFLICTING OPINION in medical writings of the value of electromyography in lumbar disc lesions. For this reason, the authors have reviewed the experience at The Ohio State University Hospitals for the five-year period from January 1, 1963 through December 31, 1968 in an attempt to gain an objective and personal view of the value of electromyography in this hospital.

In low back and lower limb pain, the EMG is used to search for evidence of spinal nerve root injury. Such a neuropathic condition, often referred to as radiculopathy, can be the result of irritation, stretching, or compression of the nerve root. This may be due to a bulging or extruded disc, or much less commonly, by spondylolisthesis, tumor, and other such disorders. It should be made clear that the EMG cannot assess the structural integrity of the intervertebral disc. No conclusions can be drawn directly from this study regarding whether the disc is intact since only the motor unit — the anterior horn cell, its axon, neuromuscular junctions, and the muscle fibers it innervates — is evaluated.

Fundamental Concepts of Electromyography¹

The EMG monitors the electrical activity of skeletal muscle just as the electrocardiogram (ECG) monitors the electrical activity of cardiac muscle. Due to the

nature of the skeletal muscle action potentials, however, the study requires the use of small-needle electrodes. The following electrophysiologic abnormalities of muscle occur when the nerve supply to the muscle is compromised:

1. Positive waves and fibrillation potentials: These are potentials that occur spontaneously with the muscle at rest, usually in association with the mechanical stimulation of needle insertion. They reveal abnormal irritability of the muscle membrane and may sometimes be seen in the most proximal muscles (paraspinal muscles) as early as eight days following onset of nerve injury. They are not present to their fullest extent until approximately three weeks have elapsed.

2. Abnormalities of individual voluntary motor unit action potentials: These potentials are evaluated during a minimal voluntary muscle contraction. The ones that continue to function after nerve injury remain normal in appearance initially. In time, potentials of abnormally large amplitude and duration may develop. In addition, polyphasic potentials (more than four phases) may occur in abnormally large numbers.

3. Abnormal decrease in number of voluntary motor unit action potentials: This factor is evaluated during maximum voluntary muscle contraction. It is seen at any time following nerve injury and is the hallmark of a neuropathic disorder. However, it may be difficult to recognize when nerve damage is slight.

The muscle being studied is considered abnormal if any one or combination of these findings are noted.

The basis of electromyographic localization of a single nerve root lesion is the finding of abnormality in a myotome distribution. (See Table.) While the EMG sometimes can reveal injury of a nerve root immediately following onset by the demonstration of decreased numbers of motor unit action potentials, a normal EMG made during the initial three weeks should be repeated after this time. False negative results can thus be avoided when abnormal irritability of muscle membrane occurs despite apparently normal numbers of voluntary potentials. The presence of abnormal irritability of the muscle membrane suggests current or recent nerve injury, while abnormally large motor unit action potentials or increased polyphasicity indicate a more chronic or long-term involvement. The relative decrease in numbers of

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 Submitted May 14, 1975.

motor unit action potentials is an indicator of the degree

of nerve injury.

The possibility of using EMG as a predictive test for lumbar disc pathology was considered as early as 1950.2 Several articles³⁻⁹ on the subject have been written since, all of which have had two features in common: (A) They attempt by EMG to determine which is the abnormal disc. This is done, first, by establishing the involved nerve root, then, equating the root with a specific disc. Accuracy, therefore, depends on both the EMG interpretation and the frequency of the disc-nerve root correlation. (B) They contrast electromyographic accuracy in predicting the involved disc with that of myelography. This is a conceptual error. 10 The EMG, a study that provides neurophysiologic information about the status of a nerve root should not be considered comparable to or interchangable with myelography, a technique that gives a direct visual record of the structural (anatomic) status of the disc. The EMG is positive when radiculopathy exists. Myelography can be positive in the presence of disc pathology whether or not nerve injury results.

Summary

The series in this report represents all patients who had lumbar disc surgery at The Ohio State University Hospitals during the five-year period from January 1, 1963 through December 31, 1968, who also had preoperative electromyography and myelography, and who had not had back surgery previously. A total of 93 such patients were identified and their records scrutinized. These patients had been treated both by orthopedists and neurosurgeons, and represented those whose surgery had been performed either by faculty members or residents. Of the 93 patients evaluated, 89 (95.7 percent)

Localization of Single Nerve Root Lesion as Determined by Myotome Distribution

Posterior Erector	spinae	L2 L3 L4 L5* S1*
		L4 L5*
		L5*
		S1*
Anterior Adduct	or longus	L2-L4
Vastus	medialis	L2-L4
Vastus	lateralis	L2-L4
Tibialis	anterior	L4-S1
Extenso	or hallucis longus	L4-S1*
Gluteus	s medius	L4-S1
Medial	hamstrings	L4-S1
Lateral	hamstrings	L5 -S 2
Perone	us longus and brevis	L5-S1*
Tibialis	posterior	L5-S1*
Lateral	head of gastrocnemius	L5-S2*
=	s maximus	L5-S2
	or digitorum brevis	L5-S2*
Medial	head of gastrocnemius	S1-S2
First d	orsal interosseus	S1-S2

^{*}EMG abnormalities strongly suggest lesion of L5 nerve root. Although distribution varies somewhat from one patient to the next, it usually is possible to establish the abnormal root.

had pathologic discs proven at surgery. Of the 67 cases with positive EMG findings, 65 (97.0 percent) had proven disc disease at surgery. This suggests a very high incidence of disc pathology as the etiology of lumbosacral radiculopathy. Yet, it is evident that a large percentage of disc pathology exists without EMG abnormality, and presumably, therefore, without injury to spinal nerve roots. This is confirmed in the present study by 20 cases with positive myelograms and 24 with pathologic discs at surgery in which EMGs were normal. The myelogram was shown to be positive in 78 (87.6 percent) of the 89 cases with proven disc pathology. It is of interest, therefore, that EMGs revealed radiculopathy in seven cases when no abnormality was apparent on myelogram. This emphasizes the difference between the two tests and reveals the value of both.

Conclusions

The value of the EMG study lies in its ability to establish whether radiculopathy exists, to localize the nerve root involved, to distinguish between an acute and chronic lesion, and to estimate the extent to which the nerve is damaged. It also can detect unsuspected neuromuscular abnormalities, such as peripheral neuropathy, that may be confusing the clinical picture. In addition, the EMG not only assesses the patient in terms of an operative procedure, but also serves as a means of noting progression or improvement of the nerve lesion, whether or not surgery is performed. The source of confusion occurs when an attempt is made to equate nerve injury and disc pathology. An abnormal EMG does not necessarily indicate disc disease; a normal EMG does not rule it out.

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 Arch Phys Med Rehabil 53:390-392, 1972.

 Johnson EW: Letters to the editor. Arch Phys Med Rehabil 55:96, 1974. main purpose of drug information for the patient is to get his cooperation in following a drug regimen.

Preparation and distribution of patient drug information

We would hope to amass information from physicians, medical societies, the pharmaceutical industry and centers of medical learning. The ultimate responsibility for uniform labeling must, however, rest with the Food and Drug Administration. There is nothing wrong with this agency saying, "this information is generally agreed upon and therefore it should be used," as long as our process for getting the information is sound.

Distribution of the information is a problem. In great measure it would depend on the medication in question. For example, in the case of an injectable long-acting progesterone, we would think it mandatory to issue two separate leaflets—a short one for the patient to read before getting the first shot and a long one to take home in order to make a decision about continuing therapy. In this case, the information might be put directly on the package and not removable at all. But for a medication like an antihistamine this information might be issued separately, thus giving the physician the option of distribution. This could preserve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

Realistic problems must be considered

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third. how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chemical and such types of material should not be included. And there is

no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively: other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him

Only the doctor can remove that fear by 20 or 30 minutes of conversation.

I'm not suggesting that we withhold any information from the patient because, first of all, it would be totally dishonest and secondly, it would defeat the very purpose of the insert. I do think that a patient on the birth control pill should know about the incidence of phlebothrombosis.

If you're going to tell a patient the incidence of serious adverse reactions, then you have to tell him that a concerned medical decision was made to use a particular medication in his situation after careful consideration of the incidence of complications or side effects.

Emotionally unstable patients pose a special problem

There are patients who, because of severe emotional problems, could not handle the information contained in a patient package insert. Yet if we are going to have a package insert at all, we just can't have two inserts. I think we might simply have to tell the families of these patients to remove the insert from the package.

Legal implications of the patient package insert

Just what effect would a pa-

tient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

How do we handle an insert for medication used for a placebo effect?

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

Preparation of the package insert

The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

Pharmaceutical Manufacturers Association 1155 Fifteenth Street, N.W. Washington, D.C. 20005



Emergency Management of Ocular Injuries

William H. Havener, M.D. Torrence A. Makley, Jr., M.D.

Injuries to the eye are common. A seeming insignificant injury elsewhere can be quite serious when the globe is involved.

This article cites some useful facts for the primary physician, who is frequently responsible for the diagnosis and management of eye injuries and the referral of the more serious wounds requiring specialized care.

IN SPITE OF THE PROTECTION afforded the eye by nature, injuries are common. Too, an injury that might be trivial elsewhere can be quite serious when the globe is involved. A tennis ball hitting one in the chest is shrugged off — not so when it hits the eye.

It is often the responsibility of the primary physician to diagnose and manage the great majority of these injuries and to recognize and refer the more serious wounds which require specialized care. The purpose of this presentation is to outline the facts which are useful in the recognition and management of eye injuries.

Equipment Needed

Expensive equipment is not necessary to evaluate and care for most ocular injuries.

Pontocaine®, fluorescein, 10 percent Neo-Synephrine[®], homatrophine, and pilocarpine are necessary eye drops. Antibiotic ointments should be handy. For magnification, a simple loop is essential. Good illumination can

be obtained with the ordinary pocket flashlight if the batteries and bulb are fresh. Irrigation fluid such as saline should be close by, and a Snellen chart should be used to record visual acuity.

Recognition

History: The physician's attention is usually directed to the eye by the patient's complaint of some type of eye injury. Because of their potentially greater danger, accidents involving gunshots, explosions, shattered glass, or metal fragments should alert the physician to the possibility of a perforating wound. Surprisingly, small perforating injuries may be almost completely painless. Hence, absence of pain is not a reliable criterion whereby to exclude eye injury. Most eye injuries cause some persistent discomfort. The physician should seek an adequate explanation for eye pain subsequent to injury.

Visual Acuity: The measurement of visual acuity is most important. Reduced acuity will alert the physician to the probability of injury and should be recorded for legal purposes. A Snellen-type wall chart should be used, and the visual acuity of each eye alone recorded.

Inspection: The usual findings indicative of injury (laceration, bleeding, swelling, ecchymosis, tissue distortion) are familiar to all physicians and do not require further description. However, certain aspects of inspection peculiar to the eye deserve comment.

Lid Separation: Until proven otherwise by careful inspection, all suspected eye injuries should be treated with the same caution as if they were known penetrating wounds. Because of the ease with which further injury may be inflicted, pressure should never be directed upon a possible lacerated eye. Particular care is necessary during separation of the lids. The upper lid is easily raised by pushing up on the brow against the frontal bone. The lower lid may be safely lowered by pulling down the skin against the maxillary rim of the orbit. Incorrect pressure upon the lids and underlying eye is less effective in exposing the eye and may damage it.

Oblique, Moving Illumination: The transparent cornea is best examined in a semidarkened room. A

Submitted March 20, 1975.

Dr. Havener, Columbus, Chief, Clinical Division of Ophthalmology, The Ohio State University Hospitals; and Professor and Chairman, Department of Ophthalmology, The Ohio State University College of Medicine.

Dr. Makley, Columbus, Clinical Division of Ophthalmology, The Ohio State University Hospitals; and Professor, Department of Ophthalmology, The Ohio State University College of Medicine.

bright, well-focused flashlight should be directed upon the eye from the side. Movement of the light will accentuate the irregular reflections which identify any defect in the normally mirror-smooth corneal surface. Conspicuous moving shadows are cast upon the underlying iris by very small corneal foreign bodies or irregularities. Side lighting clearly demonstrates the forward iris displacement characteristic of aqueous loss from a penetrating wound.

Illumination from straight in front of the eye is almost useless for detection of fine details, is much more uncomfortable for the patient, and is invariably used without success by the inexperienced examiner. Careful inspection of the injured eye with proper illumination is most important because small and inconspicuous injuries, insignificant elsewhere upon the body, may destroy sight.

Ophthalmoscopy: Although we certainly feel that ophthalmoscopic examination of the fundus of an injured eye is most important, complete discussion of this technique is too lengthy to undertake here. Many examiners are unaware that the clarity of the transparent media of the eye (cornea, aqueous, lens, vitreous) can be confirmed quickly by ophthalmoscopic examination of the red reflex. Abrasion, cataract, hemorrhage, or other defects in transparency cause recognizable faults in the red reflex. The red reflex is easily seen in a dark room by sighting through an ophthalmoscope (lens set at zero) into the patient's pupil at a distance of about one foot.

Obviously, fundus injury cannot be recognized without ophthalmoscopy. If the pupils are inadequately large, dilation with 10 percent Neo-Synephrine® solution is of

great value.

Management

Although the eventual outcome of an eye injury depends primarily upon the severity of injury, blindness often can be prevented by prompt surgical or medical care. Management will be discussed under the categories of superficial abrasions and foreign bodies, burns, contusions, lid lacerations, and penetrating injury.

Superficial Injuries of the Conjunctiva and Cornea

Conjunctival hemorrhages or lacerations are important in that they may conceal a penetrating scleral wound. Unless the conjunctiva is lacerated extensively, healing takes place rapidly without suturing. Hemorrhages in the conjunctiva are, by themselves, of no consequence although they are alarming to the patient. One must remember that a hemorrhage may cover the entrance of an intraocular foreign body or a deeper laceration of the sclera.

Corneal Abrasions

Corneal abrasions are common and usually are caused by grazing of the corneal surface by a foreign body retained under the upper lid, a fingernail, edge of a piece of paper, or a brush. The exposure of the sensory nerve endings causes severe pain, profuse tearing, photophobia, and blepharospasm. These patients are difficult

to examine until you have instilled a drop of Pontocaine®. Abrasions are difficult to see. Their extent can be delineated by staining with fluorescein strips. The area which has been abraded will stain a brilliant green. The prognosis is good and unless infection occurs, healing takes place rapidly. Small abrasions heal overnight and even large ones are always re-epithelialized in 48 hours. The treatment of uncomplicated corneal abrasions consists of instilling an antibiotic ointment and patching for 24 hours. This bandage should be sufficiently tight to immobilize the lids and prevent their movement from mechanically tearing away the regenerating epithelium. The patch, too, helps make the patient more comfortable. Topical anesthetics should not be used except initially to examine the patient as they have an inhibitory effect on epithelial regeneration. If the patient is very uncomfortable and the eye is markedly inflamed, a cycloplegic is indicated. The complication of an infection usually leads to a corneal ulcer which then becomes a very serious problem. Another complication that sometimes follows a corneal abrasion is recurrent corneal erosion. Ouite suddenly, some weeks or months after healing has taken place, the patient wakes up one morning with all the symptoms of the original abrasion. This occurs apparently without reason and may happen every two or three months for an indefinite period. Sometimes chemical cauterization is necessary to cure this complication.

Nonperforating Corneal Wounds

Nonperforating corneal wounds which traverse the substance of the cornea are rare. They may be incurred when inflicted by a sharp object or made flap-like if the sharp instrument strikes the cornea tangentially splitting it into layers. Finally, a sharp object may shave off a portion of the cornea. Amazingly, wounds of this type cause much less pain and discomfort than a simple abrasion. They frequently have retained foreign material in them which complicates treatment. Glass especially is difficult to see and remove from the wound. In small uncomplicated wounds, immobilization by patching after instilling an antibiotic ointment may be all that is needed. More extensive and irregular wounds may need debridement and suturing.

Superficial Foreign Bodies

Small superficial foreign bodies lodging in the eye are quite common. The irritation prompts the patient to seek aid almost immediately. Very often, this aid is nonprofessional with dire consequences. The foreign body often may be imbedded in the cornea. After taking the visual acuity, a drop of Pontocaine® is instilled. These foreign bodies require the use of a golf-club spud made for the purpose or a 20-gauge needle to dislodge them. The sharp point permits discrete removal of the foreign particle without damage to surrounding epithelium. Metal particles produce a brownish discoloration of the surrounding cornea known as a rust ring. This has to be picked out with the point of the needle, otherwise, healing is very slow. Topical antibiotics are very important in preventing infection until the wound heals. Occasionally,

the patient complains of a foreign-body sensation but no foreign body can be found. Don't forget to turn back the upper lid and inspect the sulcus just behind the lid margin. Cilia, too, may end up in the puncta and sometimes cause a foreign-body sensation.

Contusions

A blunt injury to the eye can cause serious damage. A black eye which is so obvious may or may not be associated with severe ocular injury. Ecchymosis of the lids will clear spontaneously, but the eye itself should be examined carefully for signs of anterior chamber hemorrhage, iris rupture, dislocated lens, or even rupture of the globe. Any hemorrhage in the anterior chamber means the contusion is serious: the patient should be hospitalized and put on bed rest with bilateral patches for at least five days. The initial hemorrhage usually clears rather promptly, but these patients are prone to have a secondary hemorrhage from the third to the fifth day which is usually severe and may cause secondary glaucoma and blood staining of the cornea. The chances of having the secondary hemorrhage are much greater if the patient is active during the first week after the injury.

Burns

Thermal: Thermal burns of the eye are not common. Occasionally, a particle from a match head will flick into the eye or a hot object will touch the cornea. The exposure is almost always momentary. For this reason, most thermal burns are superficial, involving only the corneal epithelium. Healing is rapid, and gentle cleansing plus a bland antibiotic ointment is all the treatment necessary. If there has been marked loss of the corneal epithelium, patching the eye overnight will make the patient much more comfortable. Usually the lid surface or margins suffer most of the damage. Here again, bland ointment will take care of the situation.

Chemical: Chemical burns are common in industry, in the laboratory, and not too infrequent at home. The chemical may be any number of things, alkali, acid, cleansers, solvents, and even insecticides. All important in the treatment of chemical burns is the simple emergency care which usually can be given on the spot. These eyes should be irrigated freely with plain water from a tap for 15 to 20 minutes. The lids should be held far apart so that the water bathes the eye directly. This treatment is rendered by a fellow worker or even the patient himself. When the patient arrives at the doctor's office, irrigation with normal saline is again instituted. Pontocaine® should be instilled to make the patient more comfortable. Particulate matter, such as lye crystals or plaster, must be searched for and removed from the conjunctival sac. Don't forget to turn back the upper lid and look here for foreign material. If more than one quarter of the cornea stains with fluorescein, the patient should be hospitalized and treated. We find that these patients are most comfortable with bilateral patching for several days until the epithelium heals over and there is no more staining. Homatropine, 2 percent solution, and

an antibiotic ointment may be instilled three times daily. If epithelium is denuded from the tarsal and the bulbar conjunctiva, it is possible for these two surfaces to heal together forming a symblepharon. To prevent this, mechanical separation of these structures and instillation of ointment every few hours is necessary. Sedatives and narcotics may be given for pain.

Ultraviolet: Ultraviolet burns are particularly distressing and may follow exposure to sunlamps, welding arcs, germicidal lamps, or natural sunshine. These burns are asymptomatic until several hours after they occur. Then there is intense pain and lacrimation. The cornea shows very faint, stippled stain, and there is frequently conjunctival edema. Ice packs afford these patients more comfort than anything else. Sedation and something for pain may be necessary, but usually these patients are better in 24 to 48 hours. The prolonged wearing of contact lenses gives an almost identical picture.

Lid Lacerations

Most lid lacerations can be adequately repaired by any skillful surgeon aware of lid anatomy. However, NEVER repair a lid until adequate inspection proves the underlying eye is NOT also perforated. Emergency care of such a perforating injury is of far greater importance than is lid repair.

Accurate approximation of lacerated edges is essential, particularly when the lid margin is involved. Scarification of viable tissue by debridement is unacceptable. Separate layer-by-layer closure of tarsus, orbicularis muscle, and skin will minimize scar retraction. Delicate instruments and sutures (usually 6-0) give better results. Special attention must be given to repair of avulsed palpebral ligaments, severed canaliculi, and torn levator tendon.

Whenever the sides of the lids have been torn from their orbital bony attachments, repair of the palpebral ligament with deep sutures (4-0 silk) is necessary. Skin suturing alone, although simple, tempting, and apparently adequate, will invariably result in a loose lid which droops away from the eye and, thus, will require further surgery.

Lid lacerations medial to the punctum transect the lacrimal canaliculus. Primary repair of the torn canaliculus is quite successful and relatively simple, requiring only threading of a splint through the canaliculus and careful apposition of the cut ends. Failure to repair the canaliculus initially usually dooms the patient to permanent tearing, since attempts at late repair are notoriously difficult and unsuccessful. Location of the nasal end of the canaliculus is the most difficult part of the procedure. It is a conspicious, light-colored, mucosal-lined opening about a millimeter in diameter. The usual position of a lid avulsion is such that the lower canaliculus tears off near the lacrimal sac. This torn end is NOT superficial but usually is located in the deepest and most nasal part of the wound.

When lid avulsion or laceration splits the superior margin of the upper tarsus, the levator tendon will be torn off. Permanent ptosis results unless the tendon edge is located and sutured to the tarsal edge. The normal upper lid fold is usually lost when the levator attachment is severed, but it can be restored with several sutures between the upper tarsal edge and the overlying skin.

Penetrating Injuries

Wounds penetrating into the interior of the eye always carry the danger of blindness and should be referred to the ophthalmologist for emergency care.

Proper shielding of the eye against further injury is vitally important. The semifluid ocular contents are easily squeezed through even a tiny laceration, with resultant irreparable damage. The patient, his relatives and friends, and many medical attendants almost instinctively

will wipe and dab at a bleeding or leaking eye. An adequate metal shield should be securely fastened over the eye and everyone cautioned against pressing upon the globe. Since surgical repair usually will be performed under general anesthesia, eating and drinking is forbidden. A large dose of antibiotic is important to prevent infection. Appropriate analgesics should be given as indicated — narcotics do not have any adverse effect upon the injured eye. Tetanus prophylaxis must be given at some time, but is not of emergency priority and may be delayed until after surgery. Decision as to use of mydriatics or miotics should be left to the judgment of the ophthalmologist. Undue exertion must be avoided: however, the patient may walk and can safely be transported sitting up in an automobile.



College of Surgeons Announces OB-GYN Manuscript Competition

The Obstetrics and Gynecology Specialty Group of the International College of Surgeons has announced its biennial manuscript competition. The winning author will present his paper at the International Biennial Congress in Athens, Greece, May 23-27, 1976. Round-trip air fare, hotel expenses, and \$10.00 diem will be provided.

The rules of the competition are as follows:

Fellows of the International College of Surgeons are not eligible. Contestants must be interns, residents, or graduate students in the field of obstetrics and/or gynecology. Contestants must hold the degree of doctor of medicine from an accredited college of medicine. Eligibility extends through two years after completion of training.

Manuscripts are to represent only original work by the author without coauthorship. Manuscripts are not to exceed 5,000 words. They should be typewritten on one side of each sheet, double-spaced, and with generous margins, in English, French, German or Spanish. Illustrations, if indicated, should accompany the manuscript. Original drawings or glossy photographic prints should be numbered and submitted on separate sheets. References should be listed at the end of the article and numbered, naming the author of the reference, the pages on which the article was printed, and the year of publication.

To conceal the identity of the author, manuscripts must be submitted under an assumed name. The manuscript must be accompanied by a sealed envelope, containing a card bearing the assumed name of the author, the title of the manuscript, the true name of the author, his degrees, titles, picture, and address. An original and three copies of each manuscript and illustrations must be submitted on or before February 1, 1976, to Dr. Eduard Eichner, 5 Severance Circle Drive, Cleveland, Ohio 44118.

The successful contestant will be asked to appear in person to participate in the regular scientific program of the Group on Obstetrics and Gynecology at the International Biennial Congress of the International College of Surgeons in Athens, Greece, May 23-27, 1976.

Esposito Elected President Of Amer. Opthalmology Assn.

Albert C. Esposito, M.D., of Huntington, West Virginia, is the new president of the American Association of Ophthalmology. Dr. Esposito did his residency and

investigation work in ophthalmology at The Ohio State University School of Medicine and served for seven years on the faculty of the Department of Ophthalmology.

Dr. Esposito lists among his many honors the Stritch Medal Award, the 1972 Outstanding Ophthalmologist in the South Award and the presidencies of the Southern Medical Association and the West Virginia State Medical Association. For many years he has been on the teaching staff of the American Academy of Ophthalmology. In 1974, Dr. Esposito was elected to the West Virginia Legislature and is currently the sponsor of the Medical Malpractice Bill being considered by the legislature.

Jacobson Next OSMJ News Editor

Beginning with the December issue, Linda Jacobson will become News Editor and Assistant Business Manager of *The Journal*. Ms. Jacobson will replace Jan Tanner, who will be leaving the OSMA staff. Ms. Tanner and her husband will be moving to Chapel Hill, North Carolina.

Linda Jacobson, a native of Columbus, is a 1968 graduate of the University of Illinois at Champaign where she majored in Speech and English. She taught for four years at Riverside-Brookfield High School, Riverside, Illinois, and handled the school's yearbook. More recently she has done medical proofreading and editing, most notably *Mendelian Inheritance In Man* by Victor A. McKusick, M.D., Chairman of the Department of Medicine at The Johns Hopkins Hospital.

Ms. Jacobson has a three-year-old daughter, Marli, and one brother, Carl D. Obenauf, M.D., a recent graduate of The Ohio State University School of Medicine.



Linda A. Jacobson

Parents Urged To Discuss Death With Their Children

A nationwide effort to improve communications within families about death has been undertaken by the National Institute of Mental Health (NIMH). A conference attended by both mental health professionals and communications specialists marked the beginning of the program. Representatives from such popular children's television shows as Mr. Rogers Neighborhood and The Electric Company also attended this conference aimed at encouraging communications between parents and children.

According to Dr. Stephen Goldston, Coordinator for Primary Prevention Programs in the NIMH Center for Studies of Child and Family Mental Health, "Because of cultural taboos and the reluctance of parents to bring up the subject of death and dying, the child is hard hit by the death of a loved one. The NIMH program is an important tool for the prevention of many mental health problems related to an inability to face issues surrounding death."

As a result of the conference, educational materials such as pamphlets will be developed and distributed nationally to parents and children as well as to professional and paraprofessional mental health workers.

Another aspect of the NIMH program is a contract with the National Foundation for Sudden Infant Death to develop community management systems to help families who have lost children to Sudden Infant Death Syndrome (SIDS) cope with their grief. By educating the public about SIDS and by establishing uniform procedures for health professionals to follow in reporting SIDS deaths, mental health professionals believe much of the guilt parents experience will be alleviated. They will, therefore, be better able to cope with their loss.

The NIMH is a component of HEW's Alcohol, Drug

Abuse and Mental Health Administration.

Battelle Develops Artificial Muscle

Development and evaluation of an artificial muscle system that might substitute for one of a pair of antagonistic muscles is under way at Battelle's Columbus Laboratories. The device is a silicone elastomer tube surrounding another tube of Dacron fabric. The Dacron, serving as an artificial tendon, protrudes from both ends of the silicone tube for attachment to a natural tendon or possibly to the bone itself. According to Dr. David L. Gardner, the artificial muscle is a passive device that functions similarly to a rubber band, in case a person can straighten an arm but not bend it back, the built-in ten-

sion of the muscle would allow the arm to return to its bent position.

Currently Battelle researchers are investigating methods of attaching the artificial muscle. These include suturing the Dacron fabric to the natural tendon or pinning the fabric directly to the bone where the natural tendon was originally attached. Researchers are also studying tension in natural muscles so each artificial muscle will have the same muscle tone as the one it replaces. It is hoped that the artificial muscles can be used in almost any pair of antogonistic muscles including the eye.

Medical Assistants Inaugurate Akron Woman As Natl. President

Laura L. Lockhart, a certified medical assistantadministrative from Akron, was inaugurated as the 19th president of the American Association of Medical Assistants during its annual convention.

The new president has been active in the AAMA at national, state, and local levels. She served as national vice-president, speaker of the house, vice-speaker and trustee for the AAMA. Miss Lockhart is a past president of the Ohio state chapter and assisted in organizing five new chapters in Ohio.

For the past 21 years, Miss Lockhart has been a medical assistant to Devitt L. Gordon, M.D., an ophthalmologist in Akron.

The Chicago-based AAMA is a national organization of more than 16,000 medical assistants who work under the direct supervision of a licensed physician. One of the major objectives of the Association is to increase the education and professionalism of medical assistants.

PSROs Awarded \$21 Million In Federal Gov't Grants

The federal government has awarded more than \$21 million in grants for PSROs. Forty-nine PSROs, having completed a year of planning activities, will begin to perform review of care provided in hospitals. They join 14 other comparable organizations in 12 states that have been operational during the past year. In addition, federal PSRO planning funds have been awarded to 15 new physician organizations in 11 states. These groups will begin a year of start-up activities in order to eventually qualify to begin PSRO review on a conditional basis. To provide technical and professional assistance to multiple PSROSs in some larger states, the Department of Health, Education and Welfare also funded statewide PSRO support centers in 13 states.

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Your Gift To AMA-ERF Helps Struggling Medical Students

Large numbers of medical students, interns and residents have one major barrier to hurdle before taking their place on the front line of health care delivery—the lack of adequate funding for their education.

Doctor, you can help lift this barrier through a generous contribution to the 1975 Ohio campaign for the American Medical Association Education and Re-

search Foundation.

Philip Hardymon, M.D., of Columbus, chairman of the Ohio AMA-ERF Committee, which includes the 12 district councilors of OSMA, urges an all-out effort by physicians to make the 1975 campaign a success. He cites the following statistics from last year's campaign:

•A total of 163 loans to medical students, interns and residents were made in Ohio during 1974. These

loans totalled \$213,100.

•Since the inception of the AMA-ERF Student Loan Guarantee Fund in 1962, a total of 2,188 loans totalling \$2,472,950 have been made to Ohio medical students, interns and residents.

•Medical schools in the United States received a total of \$1,016,392 from AMA-ERF in 1975. Of this total, the six Ohio medical schools received \$41,675.12.

The breakdown is as follows:

The University of Cincinnati College	of	
Medicine		4,904.69
Case-Western Reserve University Scho	ool	
of Medicine	\$	7,836.12
Medical College of Ohio at Toledo	\$	5,512.97
The Ohio State University College of		
Medicine	\$1	1,943.92
Northeastern Ohio Universities College	ge	
of Medicine	\$	685.00
Wright State University School of		
Medicine	\$	792.42

All this has been done by a private sector of the economy without government subsidy. This enviable record can be maintained with the help of Ohio physicians. Here are answers to some questions you may have concerning the Student Loan Guarantee Fund.

Did you know that through the Student Loan Guarantee Fund, the struggling medical student may receive direct financial aid?

Did you know that with increasing inflation it now costs more than \$5,000 per year to attend medical school?

Did you know that your contribution to the Student Loan Guarantee Fund will be held as a guarantee for repayment of loans? For each \$1.00 you give, another \$12.50 will be put to work in loans made by a commercial bank, and as these loans are repaid, the money is reactivated to help other students.

Did you know that the accepted applicant becomes eligible for medical education loans of up to \$1,500 a year? Additional applications may be approved each year so that a maximum of \$10,000 can be borrowed over a

seven year period.

Did you know that the borrower pays only the established interest rate during his training, and has ten years after completion of training to repay the principal?

How do you contribute? Shortly after you receive this issue of *The Ohio State Medical Journal*, you will receive a letter from Dr. Hardymon and a special AMA-ERF return envelope. The inside of the envelope includes space for your choice of medical school to receive your contribution, choice of category for your contribution, and the amount of your contribution. The pre-addressed envelope containing your contribution goes directly to AMA-ERF headquarters in Chicago.

In summary, the AMA-ERF student loan program has been designed to alleviate the financial difficulties of medical students and to encourage career decisions in favor of medicine. The functioning as a cosigning agency to make available through community banks relatively large sums of credit at a low rate of interest.

Realizing the importance of keeping medical education independent through private initiative and voluntary effort, Dr. Hardymon and members of the Ohio AMA-ERF Committee urge Ohio physicians to respond gen-

erously in this year's campaign.

YOU, Doctor, can become an important part of this program by contributing now. Where else can you buy so much for so little? Just think, a tax deductible contribution of \$125 would guarantee a medical student's loan for one year.

If you have questions or need further information concerning the 1975 AMA-ERF campaign, don't hesitate to contact the OSMA office at 600 South High St., Columbus, 43215, (614) 228-6971.

Ohio Health News

John H. Ackerman, M.D., M.P.H.

Director of Health

Toll Free Line For Reporting Communicable Diseases

To facilitate the reporting of certain communicable diseases, the Ohio Department of Health has installed a toll free telephone line that will be in operation 24 hours a day, seven days a week. The telephone number is 1-800-282-0546. Use of the line is limited to physicians and health professionals.

This is a statewide line, and we encourage all physicians to call from anywhere in the state. This line can be used to report any vaccine preventable disease or outbreaks of disease where prompt action by public health officials could avert or prevent an epidemic. For example, in cases of foodborne outbreaks or common source outbreaks of hepatitis or other enteric diseases, local health commissioners could be notified within 24 hours of any reports from their areas.

Measles Outbreak Containment Program

Although methods are available for the complete

control of vaccine preventable diseases, measles continue to cause considerable morbidity throughout the United States. In recent years, Rubeola has caused the most significant morbidity from vaccine preventable diseases in this state.

More than 2,000 cases of measles were reported to the Ohio Department of Health in 1974, while only 105 cases were reported this year through September. This low level of measles transmission leads one to think that if intensive outbreak control measures are utilized, measles eradication may be possible.

Actually, several small states have been free of measles for a number of years. It is unlikely that a state as populous as Ohio could become measles-free in the near future. However, it is reasonable that measles containment, if not eradication, could be possible in a limited geographic area where enough manpower could be concentrated. To this end, the Ohio Department of Health will institute a measles outbreak containment program in cooperation with Cleveland, Elyria and Lorain city health departments, and Lorain, Cuyahoga and Lake county health departments.



DESCRIPTION: Methyltestosterone is 17#-Hydroxy-17-Methylandrost-4-en-3-one. ACTIONS: Methyltestosterone is an oil soluble androgenic hormone. INDICATIONS: In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSPretention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. PRECAUTIONS: Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with comcnanges appear to be related to dosage of the drug. Interfore, in the presence of any changes in liver function tests,
drug should be discontinued. PRECAUTIONS: Prolonged
dosage of androgen may result in sodium and fluid retention.
This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males
for symptoms of climacteric, avoid stimulation to the point of
increasing the nervous, mental, and physical activities
beyond the patient's cardiovascular capacity.
CONTRAINDICATIONS: Contraindicated in persons with
known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence
of severe liver damage. WARNINGS: If priapism or other
signs of excessive sexual stimulation develop, discontinue
therapy. In the male, prolonged administration or excessive
dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use
cautiously in young boys to avoid premature epiphyseal
closure or precoiculos sexual development. Hypersensitivity
and gynecomastia may occur rarely. PBI may be decreased
in patients taking androgens. Hypercalcemia may occur,
particularly during therapy for metastatic breast carcinoma.
If this occurs, the drug should be discontinued. ADVERSE
REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia may cour,
particularly during therapy for metastatic breast carcinoma.
If this occurs, the drug should be discontinued. ADVERSE
REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in
patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water
retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. DOSAGE AND
ADMINISTRATION: Dosage must be strictly individualized,
as patients vary widely in requirements. Daily requirements
are best administered in divided doses.

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The success of this program, as with any public health program, depends in great measure on the cooperation of the practicing physicians who will most likely be the first to see a case of measles in their community. The containment program cannot swing into action until a measles case is confirmed. Additional information will be available to physicians in target areas at a future date.

St. Louis and California Encephalitis

A total of 750 cases of clinically suspected encephalitis or aseptic meningitis had been reported to the Ohio Department of Health as of October 1st. Almost all onset dates, with the exception of a few in late July, had occurred either in August or September. There were 58 cases of serologically confirmed St. Louis encephalitis and 35 presumptive cases. Most of the cases occurred in the following three counties:

Franklin 31 confirmed 11 presumptive Cuyahoga 8 confirmed 9 presumptive Montgomery 3 confirmed 5 presumptive In addition, there have also been a number of cases

The Vector Borne Disease Unit of the Ohio Department of Health has recovered a number of Culex

mosquitoes from areas of the state in which positive cases were identified. Thus far, there have been 18 positive mosquito pools and two birds positive for St. Louis encephalitis virus. Twelve of the positive mosquito pools were in Franklin County, some of which were from catch basins in the inner city area (these were subsequently sprayed by the Columbus City Health Department). Testing of birds in the Miamisburg area of Montgomery County revealed that 30 of 69 birds tested were serologically positive for St. Louis encephalitis virus.

The mean age for probable or confirmed St. Louis encephalitis cases is 51 years of age. Twenty-five deaths have been reported of patients with clinical encephalitis during August and September. Seven deaths have occurred in patients with probable or confirmed St. Louis encephalitis indicating a case fatality rate of 7.8 percent. The mean age for fatal probable or confirmed St. Louis encephalitis cases was 70 years.

Ten confirmed and seven probable cases of California encephalitis have been reported during August and September. These cases are scattered across the northern two-thirds of the state, but no county had more than two cases. The mean age for California encephalitis cases is eight years. One death has been reported in a two-year-old child who has been confirmed as having California

encephalitis.

Anabolic Stimulant Increased Muscular Tone Osteoporosis

scattered throughout rural counties.

EACH ANDROID-G TABLET CONTAIN	NS:
Ethinyl Estradiol	0.005 mg
Methyltestosterone	1.25 mg
L-lysine	
Nicotinic Acid	
Iron (from Ferrous Sulfate)	
Vitamin A	
Vitamin D	
Thiamine Mononitrate	
Riboflavin	
Ascorbic Acid	
Folic Acid	
Vitamin B-12	
Methionine	
Choline Bitartrate	
Inositol	
Calcium Pantothenate	
Pyridoxine	
Copper (from Copper Sulfate)	
Zinc (from Zinc Oxide)	
lodine (from Potassium lodide	
Calcium (from Dicalcium Phosphate	
Phosphorus (from Dicalcium Phosphate	
Potassium (from Potassium Sulfate)	2.5 mg
Manganese (from Manganese Sulfate)	0.5 mg
Magnesium (from Magnesium Sulfate)	0.5 mg

ACTION AND USES — DOSAGE: 1 tablet after breakfast and supper, or as required. In females, 3-week courses of therapy are recommended followed by a 1-week rest period. Withdrawal bleeding may occur during the rest period. Withdrawal bleeding may occur during the rest period. PRECAUTIONS: Administer cautiously to female patients who tend to develop excessive hair growth or other signs of masculinization. CONTRAINDICATIONS: Patients in whom estrogen or androgen therapy should not be used, as in carcinoma of the breast, genital tract, or prostate, and in patients with a familial tendency to these types of malignancy. AVAILABLE: Bottles of 100 and 500 tablets. Rx only.

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New Malpractice Law Requires Proof of Continuing Education

Ohio's new medical malpractice law requires every physician to actively pursue Continuing Medical Education (CME). Physicians must be able to certify that they have completed at least 150 hours of CME in order to be re-registered by the State Medical Board. The OSMA staff has received many questions from members concerning the new requirement, especially when it will start and how it will operate.

The Section of the law on CME reads in part:

"Every doctor of medicine licensed to practice medicine or surgery within this State shall, on or before the first day of January of every third year after the 1977 registration, apply to the State Medical Board for a certification of triennial registration with the Board upon an application which shall be furnished by the Board, and shall pay at such time a fee of fifty (\$50) dollars to the Board.

". . . The applicant shall include satisfactory evidence to the Board that in the preceding three years the practitioner had completed one hundred fifty (150) hours of continuing medical education certified by the Ohio State Medical Association and approved by the Board."

Under this law, the Ohio State Medical Board will begin triennial re-registration of physicians (instead of the current biennial) in 1980. At that time, all physicians wishing to be re-registered must certify completion of at least 150 hours of CME between January 1, 1977, and December 31, 1979. Any CME credits received in 1975 or 1976 will not be included in the first triennial registration in 1980. Only CME credits accumulated after 1977 will apply.

At present, the OSMA is working with the State Medical Board to establish a plan for the implementation of the CME requirement. As many physicians know, the OSMA has a 1975 Physician's Recognition Program with 11 categories. Because of the confusion between the OSMA's Physician's Recognition Program and the AMA's Physician's Recognition Award (which has only six categories), the OSMA is considering establishing a CME program that would run parallel to the AMA's.

By making the OSMA program similar to the AMA's, any physician who meets the CME criteria of OSMA would automatically meet the criteria of the AMA Physician's Recognition Award. Thus, specialty societies and medical organizations which have worked out mutual programs of recognition with the AMA would be automatically recognized by the OSMA.

By February 1976, with the approval of the State Medical Board, the OSMA hopes to be able to publish, in The Journal, the criteria and mechanisms for the 1977-1979 CME requirement for the first triennial regis-

tration in 1980.

If you have any further questions, please direct them to the OSMA Commission on Medical Education. IMPORTANT INFORMATION: This is a Sched-ule V substance by Federal law; diphenoxylate HCI is chemically related to meperidine. In case of overdosage or individual hypersensi-tivity, reactions similar to those after meperi-dine or morphine overdosage may occur treatment is similar to that for meperidine or morphine intoxication (prolonged and careful meditaria). Persistant descriptions morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCI) or Narcasn® (naloxone HCI) or nay be evidenced as late as 30 hours after ingestion. LOMOTIL 1S NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with special caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCI may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crists. In severe dehydration or electrolyte imbalance, withhold Lomotil until corrective therapy has been initiated.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCI and atropine are secreted in the breast milk of nursing mothers.

breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxy-late HCI is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage. Use with care in patients with acute ulcerative colitis and discontinue use if abdominal distention or other symptoms develop.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing, hyperthermia, tachycardia and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria, paralytic ileus, and toxic megacolon.

caria, paralytic lieus, and toxic megacolon.

Dosage and administration: Lomotil is contraindicated in children less than 2 years old. Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.id.; 5 to 8 years, 4 ml. (2 mg.) 1, id.; 5 to 8 years, 4 ml. (2 mg.) oldus, two tablets (5 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, hyperthermia, tachycardia, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. A narcotic antagonist may be used in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. Liquid, 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotti liquid.

SEARLE Searle & Co.
San Juan, Puerto Rico 00936

Address medical inquiries to: G. D. Searle & Co. Medical Department, Box 5110, Chicago, Illinois 60680

REPORT ON EXAMINATION OF FINANCIAL STATEMENTS FOR THE YEAR ENDED DECEMBER 31, 1974

ACCOUNTANTS' REPORT

The Committee on Auditing and Appropriations Ohio State Medical Association Columbus, Ohio

We have examined the balance sheet of Ohio State Medical Association at December 31, 1974 and the related statements of operations and net worth and changes in financial position for the year then ended. Our examination was made in accordance with generally accepted auditing standards and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the aforementioned financial statements present fairly the financial position of Ohio State Medical Association at December 31, 1974, and the results of its operations and changes in financial position for the year then ended, in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

Columbus, Ohio June 4, 1975

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Coopers & Lybrand

OHIO STATE MEDICAL ASSOCIATION BALANCE SHEET, December 31, 1974

ASSETS

Current assets: Cash, including time deposits of \$123,630 Accounts receivable, less allowance for doubtful accounts of \$337 Prepaid expenses (including \$51,960 of unamortized pension costs) Total current assets		\$ 125,280 14,804 58,658 198,742
Other assets: Due from Medical Advances Institute (Note 4)	\$ 62,717 33,699 56,000 98,780 5,570	256,766
Property and equipment, at cost (Notes 1 and 3): Land	200,987 514,020 99,389 (50,106)	764,290 \$1,219,798
Current liabilities: Notes payable to bank (Note 2) Accounts payable Current portion, term debt (Note 3) Accrued interest Other current liabilities Total current liabilities Term debt (Note 3) Deferred income: Annual membership dues (Note 1) Life membership dues (Note 1) Other Net worth (Note 8)	\$ 93,150 28,800 7,882	\$ 75,000 109,385 89,000 4,355 75,225 352,965 329,091 129,832 407,910 \$1,219,798

(The accompanying notes are an integral part of the financial statements.)

OHIO STATE MEDICAL ASSOCIATION STATEMENT OF OPERATIONS AND NET WORTH

for the year ended December 31, 1974

Income: Membership dues (Note 1) Exhibit fees Annual meeting Fees for collection of AMA dues Interest on savings accounts and certificates of deposit General Trust income Rental income Other		\$630,945 22,780 7,809 10,335 19,434 4,855 6,707 5,744 708,609
Operating expenses:		
Operating expenses: Ohio State Medical Journal net, including interest of \$2,155 Salaries Honorariums and expenses Professional conferences and scientific meetings Committee expenses Public relations Employee benefits, including pension costs of \$51,960 (Notes 1 and 5) Contributions General operating expenses, including interest of \$19,397 Loss from operations Net worth, beginning of year	\$ 87,909 238,197 75,904 81,659 23,171 686 81,933 12,282 224,025	825,766 117,157 525,067
Net worth, end of year		\$407,910
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STATEMENT OF CHANGES IN FINANCIAL POS	ITION	
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STATEMENT OF CHANGES IN FINANCIAL POS for the year ended December 31, 1974	ITION	
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STATEMENT OF CHANGES IN FINANCIAL POS for the year ended December 31, 1974 Source of funds: From operations: Loss	ITION	\$(117,157)
STATEMENT OF CHANGES IN FINANCIAL POS for the year ended December 31, 1974 Source of funds: From operations: Loss Depreciation and amortization not requiring working capital	ITION	
STATEMENT OF CHANGES IN FINANCIAL POS for the year ended December 31, 1974 Source of funds: From operations: Loss	ITION	65,562
STATEMENT OF CHANGES IN FINANCIAL POS for the year ended December 31, 1974 Source of funds: From operations: Loss Depreciation and amortization not requiring working capital	ITION	
STATEMENT OF CHANGES IN FINANCIAL POS for the year ended December 31, 1974 Source of funds: From operations: Loss Depreciation and amortization not requiring working capital (including \$51,960 relating to pension costs)	ITION	65,562 (51,595)
STATEMENT OF CHANGES IN FINANCIAL POS for the year ended December 31, 1974 Source of funds: From operations: Loss Depreciation and amortization not requiring working capital (including \$51,960 relating to pension costs) Increase in deferred income Decrease in unamortized pension cost, net of charges to operations not requiring working capital	ITION	65,562 (51,595) 26,422 9,660
STATEMENT OF CHANGES IN FINANCIAL POS for the year ended December 31, 1974 Source of funds: From operations: Loss Depreciation and amortization not requiring working capital (including \$51,960 relating to pension costs) Increase in deferred income Decrease in unamortized pension cost, net of charges to operations not requiring working capital Decrease in restricted time deposits	ITION	65,562 (51,595) 26,422 9,660 20,192
STATEMENT OF CHANGES IN FINANCIAL POS for the year ended December 31, 1974 Source of funds: From operations: Loss Depreciation and amortization not requiring working capital (including \$51,960 relating to pension costs) Increase in deferred income Decrease in unamortized pension cost, net of charges to operations not requiring working capital	ITION	65,562 (51,595) 26,422 9,660 20,192 109,923
STATEMENT OF CHANGES IN FINANCIAL POS for the year ended December 31, 1974 Source of funds: From operations: Loss Depreciation and amortization not requiring working capital (including \$51,960 relating to pension costs) Increase in deferred income Decrease in unamortized pension cost, net of charges to operations not requiring working capital Decrease in restricted time deposits	ITION	65,562 (51,595) 26,422 9,660 20,192
STATEMENT OF CHANGES IN FINANCIAL POS for the year ended December 31, 1974 Source of funds: From operations: Loss Depreciation and amortization not requiring working capital (including \$51,960 relating to pension costs) Increase in deferred income Decrease in unamortized pension cost, net of charges to operations not requiring working capital Decrease in restricted time deposits Term debt	ITION	65,562 (51,595) 26,422 9,660 20,192 109,923
STATEMENT OF CHANGES IN FINANCIAL POS for the year ended December 31, 1974 Source of funds: From operations: Loss Depreciation and amortization not requiring working capital (including \$51,960 relating to pension costs) Increase in deferred income Decrease in unamortized pension cost, net of charges to operations not requiring working capital Decrease in restricted time deposits Term debt Application of funds:	ITION	65,562 (51,595) 26,422 9,660 20,192 109,923 114,602
STATEMENT OF CHANGES IN FINANCIAL POS for the year ended December 31, 1974 Source of funds: From operations: Loss Depreciation and amortization not requiring working capital (including \$51,960 relating to pension costs) Increase in deferred income Decrease in unamortized pension cost, net of charges to operations not requiring working capital Decrease in restricted time deposits Term debt Application of funds: Acquisition of property and equipment Increase in General Trust Fund	ITION	65,562 (51,595) 26,422 9,660 20,192 109,923
STATEMENT OF CHANGES IN FINANCIAL POS for the year ended December 31, 1974 Source of funds: From operations: Loss Depreciation and amortization not requiring working capital (including \$51,960 relating to pension costs) Increase in deferred income Decrease in unamortized pension cost, net of charges to operations not requiring working capital Decrease in restricted time deposits Term debt Application of funds: Acquisition of property and equipment Increase in General Trust Fund Due from Medical Advances Institute	ITION	65,562 (51,595) 26,422 9,660 20,192 109,923 114,602 223,774 4,855 50,670
STATEMENT OF CHANGES IN FINANCIAL POS for the year ended December 31, 1974 Source of funds: From operations: Loss Depreciation and amortization not requiring working capital (including \$51,960 relating to pension costs) Increase in deferred income Decrease in unamortized pension cost, net of charges to operations not requiring working capital Decrease in restricted time deposits Term debt Application of funds: Acquisition of property and equipment Increase in General Trust Fund Due from Medical Advances Institute Reduction in term debt	ITION	65,562 (51,595) 26,422 9,660 20,192 109,923 114,602 223,774 4,855 50,670 95,909
STATEMENT OF CHANGES IN FINANCIAL POS for the year ended December 31, 1974 Source of funds: From operations: Loss Depreciation and amortization not requiring working capital (including \$51,960 relating to pension costs) Increase in deferred income Decrease in unamortized pension cost, net of charges to operations not requiring working capital Decrease in restricted time deposits Term debt Application of funds: Acquisition of property and equipment Increase in General Trust Fund Due from Medical Advances Institute	ITION	65,562 (51,595) 26,422 9,660 20,192 109,923 114,602 223,774 4,855 50,670 95,909 5,026
STATEMENT OF CHANGES IN FINANCIAL POS for the year ended December 31, 1974 Source of funds: From operations: Loss Depreciation and amortization not requiring working capital (including \$51,960 relating to pension costs) Increase in deferred income Decrease in unamortized pension cost, net of charges to operations not requiring working capital Decrease in restricted time deposits Term debt Application of funds: Acquisition of property and equipment Increase in General Trust Fund Due from Medical Advances Institute Reduction in term debt Other	ITION	65,562 (51,595) 26,422 9,660 20,192 109,923 114,602 223,774 4,855 50,670 95,909 5,026 380,234
STATEMENT OF CHANGES IN FINANCIAL POS for the year ended December 31, 1974 Source of funds: From operations: Loss Depreciation and amortization not requiring working capital (including \$51,960 relating to pension costs) Increase in deferred income Decrease in unamortized pension cost, net of charges to operations not requiring working capital Decrease in restricted time deposits Term debt Application of funds: Acquisition of property and equipment Increase in General Trust Fund Due from Medical Advances Institute Reduction in term debt	ITION	65,562 (51,595) 26,422 9,660 20,192 109,923 114,602 223,774 4,855 50,670 95,909 5,026

(continued on next page)

(The accompanying notes are an integral part of the financial statements.)

(continued)

Changes in the components of working capital:

Increase (decrease) in current assets:	
Cash	\$ 22,861
Accounts receivable	5,692
Accrued interest receivable	(299)
Prepaid expenses and unamortized costs	` 10,849´
	39,103
Increase in current liabilities:	
Notes payable to bank	75,000
Accounts payable	61,155
Current portion, term debt	89,000
Accrued interest	4,355
Other current liabilities	75,225
	304,735
Decrease in working capital	\$ 265,632

(The accompanying notes are an integral part of the financial statements.)

NOTES TO THE FINANCIAL STATEMENTS

Accounting Policies:

The following is a summary of certain significant accounting policies followed in the preparation of the financial statements. The policies conform to generally accepted accounting principles and have been consistently applied.

a. Depreciation:

The Association provides for depreciation on the straight-line and declining-balance methods in amounts adequate to amortize costs over the estimated useful lives of the assets. Depreciation charged to operations during 1974 was \$13,602.

b. Deferred Membership Dues:

Income from annual membership dues is recognized in the calendar year to which they apply. Life membership dues income is recognized over 25 years of active practice of the life membership participants.

c. Prepaid Pension Costs:

At the inception of its qualified pension plan during 1969, the Association fully funded all costs of the plan, which amounted to \$386,900. The prepaid costs are being amortized on an approved actuarial method each year, such annual provision consisting of normal cost plus 10% of the frozen initial liability (past service costs), reduced by interest on the unamortized prepaid costs.

Notes Payable to Bank:

Notes payable to bank at December 31, 1974 consist of the following:	
14%, 90-day unsecured note due January 2, 1975	\$25,000
13-3/4%, 73-day unsecured note due January 2, 1975	
12-3/4%, 44-day unsecured note due January 2, 1975	
	\$75,000

(continued)

3. Term Debt:

Term debt at December 31, 1974 consists of the following:

in dest at becomes of, 1077 comme of the following.	Current Maturiti es	Due After One Year
Unsecured promissory note to bank at 1-1/2% above prime		
payable in annual installments of \$75,000, balance due		
March 15, 1977	\$75,000	\$150,000
8% Mortgage loan payable in monthly installments, balance		
due July 1, 1984	14,000	179,091
	\$89,000	\$329,091
	<u> </u>	<u> </u>

During July 1974, the Association completed construction of its building at 600 South High Street, Columbus, Ohio, and refinanced a \$500,000 construction loan by obtaining an unsecured, \$300,000 term loan at 1-1/2% above prime and an 8% mortgage loan of \$200,000 from the Ohio State Medical Association Pension Trust Fund. The mortgage loan is collateralized by the land and building at 600 South High Street. The Association has capitalized interest on the above construction loan amounting to \$16,491 in 1974.

Due from Medical Advances Institute:

The Association has advanced funds, primarily noninterest bearing, to Medical Advances Institute (MAI), an Ohio Corporation not for profit, to support this organization's development of a peer review system for the medical profession. Subsequent to December 31, 1974, the Association advanced MAI an additional \$12,500 at 9% for six months. The recovery of funds advanced to MAI is generally dependent upon the successful development and marketing of the system, which is currently in the developmental stage.

Pension Plan:

The Association has a salaried employees' pension plan covering substantially all of its employees. (The Association funded the entire cost of the plan at its inception) (see Note 1). The total pension expense for the year was \$51,960, which included normal costs of \$26,500 and past service costs of \$34,200, reduced by interest of \$8,740 on the unamortized prepaid pension costs. At December 31, 1974, the actuarially computed value of vested benefits exceeded plan assets by \$29,000.

Leases: 6.

The minimum rental commitments of the Association under all noncancelable leases were as follows at December 31, 1974:

·	1975	1976	1977
Equipment	\$ 800		
Automobiles	6,456	\$4,584	\$296
	\$7,256	\$4,584	\$296

Rental expense under these and similar leases aggregated \$43,611 during 1974.

Investment—Ohio Medical Indemnity, Inc.:

The Association owns 100% of the outstanding common stock, 8,000 shares, of Ohio Medical Indemnity, Inc. purchased at a cost of \$56,000. The Board of Directors of Ohio Medical Indemnity, Inc. (Blue Shield) is prohibited from declaring or paying any cash dividends upon such common shares of stock of the Company. In the event of liquidation of the Company, the shareholder (Ohio State Medical Association) shall be paid a sum equal to the price paid for such shares, \$56,000. The Company, having an equity of \$41,929,000 at December 31, 1974, shall at liquidation distribute its remaining assets to the Association, or its successor organization, to be used solely and exclusively for medical research, medical education, or the development and establishment of medical care plans.

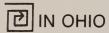
Exemption—Federal Taxes on Income:

The Ohio State Medical Association is exempt from federal taxes on income under Section 501(c) (6) of the Internal Revenue Code.

NOTICE TO ALL MEMBERS

- Your Membership in the Ohio State Medical Association and American Medical Association, including subscriptions to The Ohio State Medical Journal and The Journal of the AMA will expire on December 31. Here's how to renew them:
- Mail your dues immediately to the Secretary-Treasurer of Your County Medi-CAL SOCIETY or to the OSMA if your County Society has asked OSMA to direct bill for all three levels of dues on behalf of the Society.
- OSMA dues are \$125.00. AMA membership dues are \$250.00. Check with your local Secretary-Treasurer to determine the amount of your County Society dues. Ohio Medical Political Action Committee-American Medical Political Action Committee dues are \$35. OMPAC-AMPAC membershp is recommended.
- Life Active membership—a category of membership approved by the 1973 House of Delegates. This membership is available to 500 physicians who make a single, lifetime dues payment of \$1,250.00. When this payment is made, the life active physician is assured a full, active lifetime OSMA membership, subject only to maintenance of Ohio license and adherence to the Principles of Medical Ethics.
- Many members probably will want to send one check to cover local, state, national, and OMPAC-AMPAC dues. Your local Secretary-Treasurer will forward your state and national dues to the OSMA Columbus Office. That office will certify AMA dues. OMPAC-AMPAC dues will be forwarded to OMPAC Headquarters.
- As part of the privileges and services offered to all members of the OSMA, you will receive a year's subscription to The Ohio State Medical Journal and copies of the OSMAgram, without extra cost. Dues-paying members of the AMA will receive a year's subscription to The Journal of the AMA and the American Medical News.
- The member who becomes eligible for exemption from dues, and wishes to take advantage of exemption, should notify the secretary-treasurer of his County Medical Society. After exemption has been established, it is automatically renewed annually, unless the status changes.

CONTINUING



OB-GYN Infections; Nov. 19; Hilton Inn, Olentangy River Rd., Columbus; co-sponsored by the Columbus OB-GYN Society and the Ohio Section of the American College of Obstetricians and Gynecologists.

Management of Selected Common Problems of the Aged Ill; Nov. 20; Daniel Drake Memorial Hospital, Cincinnati; cosponsored by Office of CONMED, University of Cincinnati College of Medicine; \$40 registration fee; acceptable for 7 hours credit toward AMA Physician's Recognition Award, Category 1.

Practical Endocrinology; Nov. 21; University of Cincinnati Medical Center; contact the Office of CONMED, Dean's Office, Suite E251, 231 Bethesda Ave., Cincinnati 45267.

Cardiology Symposium; Dec. 3; Fawcett Center for Tomorrow, 2400 Olentangy River Rd., Columbus; sponsored by the Ohio State University Center for Continuing Medical Education, 320 W. 10th Ave., Columbus 43210; \$40 registration fee.

Management of Rheumatoid Arthritis; Dec. 3-4; University of Cincinnati Medical Center; contact the Office of CONMED, Dean's Office, Suite E251, 231 Bethesda Ave., Cincinnati 45267.

Perspectives in Ophthalmology; Dec. 3-4; sponsored by the Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; \$80 registration fee.

Ohio Medical Education Network Programs (see the October 1975 issue of The Journal, page 733, for explanation):

Breast Cancer Screening, Detection and Diagnosis, Dec. 1-5

Diabetic Hyperlipidemia and Hyperglycemia, Dec. 8-12 Clinical Pathological Conference (Adult), Dec. 15-19 Value of Staging and Therapy in Management of Lymphomas, Jan. 5-9

Recurrent Lower Urinary Tract Symptoms, Jan. 12-16 Selection of Antibiotics, Jan. 19-23

Amniocentesis, Jan. 26-30.

Nuclear Medicine; introductory one-week course for physicians; Dec. 8-12; co-sponsored by the Nuclear Medicine Institute, 6780 Mayfield Rd., Cleveland 44124, and Hillcrest Hospital; \$400 registration fee, \$200 for residents.

Hospital Diets; Dec. 9; sponsored by the Fort Steuben Academy of Medicine, 525 N. 4th Street, Steubenville.

Endocrinology; Dec. 13-14; Fawcett Center for Tomorrow, 2400 Olentangy River Rd., Columbus; sponsored by the Center for Continuing Medical Education, 320 W. 10th Ave., Columbus 43210; \$50 registration fee.

Current Blood Bank Problems; Jan. 7-8; Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; \$80 registration fee; acceptable for Category 1 credit toward AMA Physician's Recognition Award.

Family Medicine Review; Jan. 10-11 and/or 24-25; Imperial House N., Interstate 71 and Morse Rd., Columbus; sponsored by the Ohio Academy of Family Physicians, 4075 N. High St., Columbus 43214; registration fee \$25 resident, \$75 member, \$125 non-member (per weekend).

Medical Problems Encountered In Sex Counseling Clinic; Jan. 13; sponsored by the Fort Steuben Academy of Medicine, 525 N. 4th Street, Steubenville.

Surgical Technics, "How I Do It"; Jan. 14-15; Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; acceptable for Category 1 credit toward the AMA Physician's Recognition Award.

Core Curriculum: Pediatric Echocardiography; Jan. 19-22; Children's Hospital, Cincinnati; sponsored by the American College of Cardiology, 9650 Rockville Pike, Bethesda, Md. 20014; registration fee \$150 member American College of Cardiology, \$200 non-member.

Cytogenetic Endocrinology Teratology; Jan. 21, Marriott Inn, Cleveland; sponsored by the Cleveland Society of Obstetricians and Gynecologists, 1445 Blackmore Rd., Cleveland Heights 44118.

Gastroenterology Seminar; Jan. 28; Fawcett Center for Tomorrow, 2400 Olentangy River Rd., Columbus; sponsored by the Ohio State Center for Continuing Medical Education, 320 W. 10th Ave., Columbus 43210; \$40 registration fee.

Medical Progress for the Family Physician; Jan. 28-29; co-sponsored by the Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106, and the Cleveland Academy of Family Practice; \$60 registration fee; acceptable for Category 1 credit toward AMA Physician's Recognition Award.

Core Content Review; Jan.-June (home study); sponsored by the Ohio Academy of Family Physicians, 4075 N. High St., Columbus 43214; registration fee \$40 member, \$60 nonmember.

OUTSIDE OHIO

Management of Rheumatoid Arthritis; the allied health professional's role; Nov. 20; Breckinridge Inn, Louisville; cosponsored by the University of Louisville School of Medicine and the Kentucky Chapter of the Arthritis Foundation; for further information contact Marilee Phillips, R.N., Kentucky Arthritis Foundation, 1381 Bardstown Rd., Louisville 40204.

University of Michigan Courses; Towsley Center for Continuing Medical Education, Ann Arbor; for further information contact Robert K. Richards, Director, Office of Intramural Education, G1109 Towsley Center, University of Michigan, Ann Arbor 48104.

Plastic Surgery for General Surgeons, Nov. 20-22 Common Genito-Urinary Problems in Family Practice, Nov. 22 (a.m.)

Cardiology for Family Physicians, Dec. 3 Electrocardiographic Diagnosis, Jan. 13-15.

Trauma; 23rd annual symposium; Dec. 5-6; Harper Hospital, 3990 John R St., Detroit; co-sponsored by the Michigan Committee on Trauma of the American College of Surgeons and Wayne State University Department of Surgery; for further information contact Joseph L. Posch, M.D., Chairman.

Fluid and Electrolyte Balance, Hypertension and Renal Disease; Dec. 8-12; Passavant Pavillion, Northwestern Memorial Hospital, Chicago; co-sponsored by the American College of Physicians and Northwestern University Medical School; acceptable for Category 1 credit toward the AMA Physician's Recognition Award; for further information contact Registrar, Postgraduate Courses. ACP, 4200 Pine St., Philadelphia 19104.

Pediatric Nephrology III; current concepts in diagnosis and treatment; Jan. 5-8; Americana Hotel, Bal Harbour, Fla.: sponsored by the University of Miami School of Medicine; acceptable for Category 1 credit toward the AMA Physician's Recognition Award; for further information contact the Division of Continuing Medical Education, University of Miami School of Medicine, P.O. Box 520875 Biscayne Annex, Miami 33152.

Physiology, Diagnosis and Treatment of Electrolyte and Acid-Base Disorders; Jan. 5-9; co-sponsored by the American College of Physicians and the University of Pennsylvania School of Medicine; for further information contact Registrar, Postgraduate Courses, ACP, 4200 Pine Street, Philadelphia 19104.

OB-GYN; Jan. 11-17; Frenchman's Reef, St. Thomas, U.S. Virgin Islands; co-sponsored by the University of Miami School of Medicine and the Virgin Island Medical Society; for further information contact the Division of Continuing Medical Education, University of Miami School of Medicine, P.O. Box 520875 Biscayne Annex, Miami 33152.

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Epidemics In Early Ohio

B. Gordon Moore

The pioneers found in Ohio an ideal dwelling place—almost. There was fertile soil, ample rain, building material for the taking and a climate tolerable for man and beast. However, Ohio was not a health paradise. Settlers and travelers alike testified to the alarming amount of illness, especially the frequent epidemics that swept across sections or the whole state.

Perhaps one of the most dramatic epidemics was reported in the Central Ohio area in 1819. Dr. William Morrow Beach of London (Ohio), writing some 60 years later, gave a vivid account of the epidemic. His paper was presented before the Ohio State Medical Society

meeting in Cleveland in 1884.

"In the year 1819," he wrote, "thirty young men left Worthington, Ohio, and went up to Sandusky, Ohio, to assist in the making of craft for the carrying trade of the lakes. . . At Sandusky in the same season of their adventure, they all got sick. Some died on the way home, and some after reaching home; but of the thirty all died but one. It is said of the one who ultimately recovered, that 'nearly all the flesh fell away from his bones.' What was meant by this expression, I am not able to say; but it is an expression that I find three times repeated in private correspondence, which I have in my possession. One of these victims was my mother's youngest brother—John Adams Noble . . ."

Malaria was well known to the physicians of the period, but apparently, characteristics of this particular

disease puzzled them. Dr. Beach continues:

"The fever of which these young men died was probably not typhus or ship fever; nor was it probably typhoid, as the testimony of such of the older citizens as I knew and talked with on the subject is uniform that it was neither infectious nor contagious; but it was a long continued fever."

It is interesting to note Dr. Beach's use of the terms "infectious" and "contagious" in this context. Perhaps he suspected the necessary presence of a vector.

Strange as it may seem today, malaria was one of the most prevalent epidemics in virtually all parts of Ohio. Mostly it was an "intermittent fever" episode, but now and again it broke out in violent form, (Dr. Thomas Sharkey of Dayton, in a 1946 article, noted that it is theoretically possible for malaria to reinfect Ohio since the offending Anopheles mosquito is still with us in limited numbers.)

It is ironic that the early physicians did not associate the spread of malaria (the "bad air" disease) with the bite of the mosquito. As early as 1818, William Darby ascribes one of the causes of the disease to "the loss of rest from the sting of the mosquito." He further states that standard equipment for a person traveling the Mississippi Valley was a "mosquito curtain." Whether or not Dr. Beach relates the following "malarial type" epidemic to the experience of the 30 young men is uncertain. His report goes from one episode to the other, but leaves a four-year gap. The second source of information reports the "sickly season" in Columbus as early as the summer of 1821.

Dr. Beach continued his report as follows:

"The years 1823 and 1824 were attended with such a frightful amount of sickness, that to this day, in Central Ohio, they are referred to as 'the sickly seasons.' Its center of virulence was probably the Darby Plains region, now included in the counties of Madison, Union and Champaign." He then describes the low lying areas, the abundance of rain and the hot summer months, and concludes, "the conditions that experience has taught the people over there are most conducive to sickness of the malarial type."

In further describing conditions, Dr. Beach points out some characteristics of this plague that were unlike "ordinary intermittents," as malarial attacks were called.

"With about the commencement of the month of July — both seasons — a scourge of sickness fell upon the people. Its prodromic stage was sometimes two or three days, and characterized by weariness, ostalgia and dull headaches. Sooner or later the patient was seized with chilliness, which might last for several hours. A fever followed — of a remittent character, generally, but declining later, if the patient survived, into an intermittent — which would run on indefinitely. Usually, about the second or third day, the patient became icteroid, and sometimes so continued until convalescence, which, without the aid of periodics, was likely to be long delayed.

"All patients did not fare even so well as this, for many of them died within two or three days, probably of local congestion, at the period corresponding to the chill stage in ordinary intermittents; in this feature of the cases resembling pernicious fever, or the 'sinking chills' of a

later period.

"The universality of the sickness was such, over on the Darby Plains, where my people then lived, that there were not well ones enough to bury the dead, much less to care for the sick. Those who were able to work patrolled the settlements, going from house to house asking for the dead who needed burial; and the bodies of some remained in the cabins, where others were sick, until decomposition was far advanced. "... The virtues of indigenous plants were probably then but little known, and the most of such knowledge that was then current was borrowed from the Aborigines. The chief reliance among the physicians was probably calomel and jalap, sulphate of magnesia, and phlebotomy. Eupatorium perfoliatum was used extensively in domestic practice, as an emetic and cholagogue."

Columbus was hit hard by the epidemic. David Deshler, founder of the well-known Deshler family but then a struggling carpenter, was taken seriously ill. His wife Betsy left some excellent accounts of life in the pioneer community, among them descriptions of this

scourge. In September, 1821, she wrote:

"We have had nothing but sickness and trouble in our family since June. David was taken with the bilious fever on the first of July and was confined to bed for nearly seven weeks, and part of that time entirely deranged. Without help I took care of him fourteen nights in succession." (She probably was referring to lack of nursing help, since there were well-qualified physicians in Columbus at the time.)

Betsy Deshler wrote more in 1822 about the epidemic and the economic depression of that period. In

August, 1823, she wrote:

"Our town is at present nothing but a scene of trouble, sickness and death. If you go to the door at midnight you see a light in almost every house, for watching with the sick and dead. No business of any kind doing, our town perfectly dull, people in the country sick and strangers afraid to pass through the town."

In October of 1823, she wrote of the appalling conditions in the Darby Plains area, later confirmed by Dr.

Beach:

"On a small stream called Darby, about eighteen miles from here, there are scarcely enough people to bury the dead. In one instance a mother was compelled to dig a grave and bury her own child in a box that was nailed up by herself without one soul to assist her. Only think of it! Another case was that of a man, his wife and four children who had settled three miles from any other house. The father, mother and all took sick and not one was able to hand another a drink of water, or make their situation known. At length a man in search of his horse happened to call at the house to enquire and found a dead baby four days gone in the cradle, the other children dying, the father insensible, and the mother unable to raise her head from the pillow.

"In another family, ten in number, only a few miles from town, all were sick except two small children who actually starved to death, being too small to go to a neighbor or prepare anything for themselves . . ."

Malaria was a constant problem in all areas of Ohio. It was especially troublesome during the digging of the canals, beginning in 1825. In the summer of 1827, work on the canals, people some to a help

on the canals nearly came to a halt.

Workers to dig the canals were hired by the thousands, mostly Irish immigrants. At first, the pay was "30 cents a day, food, whisky and shanty." The routes of the canals naturally followed the lowlands and the canal system was called among other things, an "Irish graveyard."

"Our town (Columbus, 1823) is at present nothing but a scene of trouble, sickness and death."

Peruvian bark was the standard remedy for intermittent fever in the early years, but by the 1820's quinine had been isolated from the same product. Doses of quinine, calomel and blue mass were handed out indiscriminately to the canal workers. Whiskey was given without stint as a protection against malaria. In the Toledo area, it was reported that every few hours a boy would pass along the lines of diggers and give each man his "jigger full" of whiskey. In the Toledo area, the malady was referred to as "Maumee fever."

Chorera

Cholera was generally the most severe, though not the most prevalent, disease of Ohio. It took various forms, some more dangerous than others. Early settlers referred to "cholera morbus" and a related form, "cholera infantum."

Parenthetically, it should be stated that these terms are used here in the historical sense. Blakiston's Medical Dictionary defines cholera morbus as an "old term applied to any inflammatory enteritis with pain and purg-

Epidemics/Continued

ing." It further defines cholera infantum as an "old term applied indiscriminately to diarrheal conditions in infants and young children."

None of the forms of the disease could compare to the dreaded Asiatic cholera which struck Ohio in 1832 after starting in India, sweeping across Europe and into America. The epidemic appeared in Europe in 1830. It struck Paris hard in April of 1832, reportedly killing 7,600 people in that city in two weeks. By mid-May, some 1,380 deaths were reported in London and by mid-July, it was sweeping the United States from the east coast. As one observer remarked, it "is here and everywhere, a demon that rides upon the wind, and dives into every corner of the earth."

The city clerk of Cincinnati, in the last summer of 1832, reported 117 deaths by "epidemic cholera" in a week. A Cincinnati physician reported that people were dying of cholera at the rate of 40 each day.

On November 9, 1833, the Columbus Board of Health published its final report for the season. It read in part: "The first case of cholera occurred among us on the 14th day of July and the last on the 29th day of September. Between these two dates the total number who fell victim to this disease within the limits of the town (Columbus) was 92 of which 11 were among prisoners in the Penitentiary. The total number of inhabitants in this town at the time the cholera appeared among us is supposed to have been about 3,500 of whom nearly one-fourth part removed temporarily from the town during the prevalence of the disease."

On the first of June, 1834 the Asiatic cholera returned. In the Columbus area, it reportedly hit the penitentiary unusually hard. Among Columbus area physicians who fell victim to it were Drs. Horace Lathrop, Isaac F. Taylor and B. F. Gard. Dr. John M. Edmiston, pioneer Columbus area physician, died in 1834 at the age of 44, but apparently not of the disease itself. It was said of him that he died "because he refused to rest when his services were so essential to the well-being of the community."

Heroic deeds of physicians were numerous. For example, in May, 1833, the eminent Dr. Thomas Flanner of Zanesville, hearing that cholera was raging in Wheeling, Virginia (now West Virginia) went there to study its characteristics "before it might reach the people who might look to him for advice." He fell victim to the disease and died on June 6 of the same year.

Few reports of cholera appeared for another 15 years. In 1849, it struck the Midwest and West again, being particularly violent along the borders of Lake Erie. Hewson L. Peeke in his **Standard History of Erie County** states that 357 persons in Sandusky died in 68 days from cholera. This was from a population "probably not over 4,000, more than half of whom left the city when the cholera was at its height." Victims were buried en masse.

Peeke reports one observer as saying, "There were fifty people put in the trench in three days..."

Neither was the rest of the state spared. An observer in southwestern Ohio reported that the disease was at its height "in the hot month of July (1849), yet great fires were made in some streets with the idea of driving off the poison; but the disease went on with its fearful fatality, and the long funerals blackened all the way . . ."

The first Ohio State Fair got off to a belated start because of the Asiatic cholera epidemic. The fair was scheduled for its initial opening in 1849 at Camp Washington near Cincinnati. It was postponed to the following year. In 1850, the opening was again postponed because of the cholera threat, but this time only for a month. Once opened, the fair proved to be a huge success and has since been one of the outstanding fairs of the nation.

"The first Ohio State Fair (1849) got off to a belated start because of the Asiatic cholera epidemic."

There was a brief return of the epidemic in 1852, and probably in 1853 and 1854. Dr. Edwin W. Mitchell of Cincinnati, writing in 1937, indicated that the last Asiatic cholera epidemic, as far as southwestern Ohio was concerned, was in 1873. In that year, there were 740 deaths in Ohio reported due to cholera, 207 of them in Cincinnati.

Smallpox

Smallpox was no stranger to Ohio pioneers. It was especially troublesome along the shipping lanes—the Ohio River and Lake Erie. Dr. Samuel Prescott Hildreth reported epidemics of smallpox at Belpre from 1790 to 1795.

Dr. Richard Allison, army surgeon, in a letter dated June 23, 1794, touched on conditions at Camp Washington, at Cincinnati, and noted "the great number of sick in this garrison." Dr. David Strong was more specific. On Jan. 15, 1795, Dr. Strong wrote from the same camp of "natural smallpox, which now prevails with great virulance in this place." (Dr. Strong's reference may

have included the civilian population, since army surgeons were authorized about this period to treat civilians.)

After he had retired from army life and moved to an estate east of Cincinnati, Dr. Allison wrote to a friend apologizing for a delay in a promised visit. The reason was a little girl "dangerously ill in the last stage of a confluent small-pox, but a few days will determine her fate." He promised to bring his friend the "vaccine matter." This was in 1803.

Ohio settlers were fortunate in their relation to the inoculation time clock. A form of direct inoculation against smallpox was practiced in ancient China. In Europe, direct inoculation was known for years before Jenner introduced his vaccination method. Direct inoculation was introduced in Canada as early as 1765, and was practiced in the Colonies during the Revolutionary War. By this method, persons exposed to the disease were inoculated with a scab or some pus from a patient with a mild case of smallpox. On July 17, 1792, smallpox broke out among the troops at Detroit, and a Dr. Carmichael was ordered to inoculate all those in the detachment who had never had the disease.

Jenner introduced his method of vaccination in 1798, and Benjamin Waterhouse employed it in the United States.

Lewis and Clark had vaccine on their exploration of the Louisana Purchase. President Jefferson wrote to Lewis on June 20, 1803: "Carry with you some matter of kine-pox... as a preventive from the small-pox." Lewis was well acquainted with use of the vaccine and wrote back to the President requesting a fresh supply, because "I have reason to believe from several experiments made with what I have that it has lost its virtue."

The Indians seemed particularly vulnerable to small-pox. Whole camps and even whole tribes were virtually wiped out by the scourge. Dr. William Thomas Corlett reported that Dr. Peter Allen, of Kinsman in Trumbull County, was called upon when a tribe near Ashtabula was threatened with extinction. Dr. Allen found the medicine man immersing the patients in a pit filled with mud, heated with stones. All so treated died. Dr. Allen then vaccinated those not already afflicted and the epidemic was stamped out. Dr. Corlett's article does not give the date of this incident, although Dr. Allen began his practice in Kinsman in 1808.

Milksickness (Snakeroot Poisoning)

The medical dictionaries define an epidemic as the unusual prevalence of a disease. By that definition, milk-sickness was epidemic in southwestern Ohio, as well as in other frontier areas.

Ironically, milksickness was so called because cattle displayed much the same symptoms as man. It was known by many names—the trembles, the staggers, the tires, the slows, the bloody murrain, swamp sickness, river sickness, puking fever, etc. However, most of the frontier people referred to it as milksickness.

Numerous theories were advanced as to its cause. The eminent Dr. Daniel Drake of Cincinnati, as early as 1810 suggested that it might be traced "to the use, by animals whose milk and flesh are eaten of some deleterious plant." This same theory was echoed by others and even the guilty plant itself was named, but no one followed these observations to a conclusion.

Thomas Ashe, as early as 1806, identified milk-sickness along the Ohio River. Thomas Barbee, a Virginia physician traveling through Ohio, reported it in the Mad River area. Flagg reported whole villages in Illinois depopulated by it and panic prevailing among the settlers in those areas. It was not until well into the 20th century that the cause was definitely traced to a poison in species of the snakeroot plant and certain other plants. It was transferred to persons through the milk and meat of poisoned animals.

Yellow Fever

Ohio apparently did not experience any spread of yellow fever, although the disease was known in epidemic proportions along the East Coast as far north as Philadelphia and New York. A survey commissioner reported yellow fever in Gallipolis in 1797. Dr. Daniel Drake in his book on principal diseases of North America refutes this. He wrote: "Gallipolis is the only town of the Ohio Basin which has been charged with generating yellow fever." He then discusses the circumstances of the report and concludes, that it "was held by many physicians to be only the highest grade of our indigenous autumnal fever . . . all (reports) militate against the conclusion that the epidemic was yellow fever."

Dr. E. W. Mitchell, writing in 1937 as emeritus professor at the University of Cincinnati College of Medicine, stated that "One might make the chapter on yellow fever in Cincinnati almost as short as the one on snakes in Ireland." Dr. Mitchell then reports on some interesting cases of yellow fever in Cincinnati in the 1870's all imported from down river with two exceptions. One exception was that of a maid at a boatman's boarding house who had spread baggage out to dry. The other was a drayman who had hauled bales of goods from the boats. The implication is that the infected mosquitoes were trapped in the baggage and imported into the city.

Dr. N. Paul Hudson, writing in 1965 as Emeritus Professor of Microbiology at The Ohio State University, presented a comprehensive discussion on yellow fever along the Ohio River. He had done extensive research on yellow fever under the Rockefeller Institute. He too questioned whether yellow fever could be "engendered" in Ohio, and stated that "Ohio is not now" within the

Epidemics/comme

zone of the Aedes aegypti (mosquito). He suggested that the mosquito may have been imported in the bilge water of boats and barges.

Discourage of the last of the

Tuberculosis, or consumption, as it was called, was perhaps the stealthiest of all frontier diseases, and for that reason, was not dreaded by early settlers like the more dramatic epidemics. Dr. Daniel Drake wrote in 1815 that the prevailing disease in Cincinnati was pulmonary consumption. As late as 1944, tuberculosis was listed as the seventh highest cause of death in the United States.

Althor Marin Hitzonyo

According to many authorities, few early settlers sought the help of physicians except in extreme illness. The epidemics apparently provided the exception. Epidemics took their toll of doctors, primarily because of overwork.

Dr. Samuel Prescott Hildreth arrived in Marietta (and in Ohio) in 1806. Since there were two physicians already in Marietta, he moved down river to Belpre where he became the only physician at that time. The next year an epidemic of "fever" raged along the Ohio River. Dr. Hildreth labored day and night, sometimes traveling as far as 30 miles into the wilderness to attend patients. His treatments were said to have been singularly successful. The work, however, proved too much for him. After suffering for months with an inflammation of the hip, he returned to Marietta.

In addition to smallpox, Dr. Hildreth reported as serious epidemics, scarlatina at Belpre from 1790 to 1795 and malignant fever at Gallipolis in 1796. He cited as other epidemics, measles, whooping cough, diphtheria, influenza, malaria, milk fever and dysentery.

Paul M. Davis and Philip D. Jordan, professors of history at Miami University, noted among other epidemics in southwestern Ohio, an epidemic of typhoid fever reported in the winter of 1816-1817. Other ailments they reported were pneumonia, pleurisy, rheumatism, typhus, and many lesser ailments.

Dr. Daniel Drake in his 1815 report on prevailing diseases in Cincinnati, listed, in addition to consumption, pleurisy, croup, cholera morbus and cholera infantum, colds and catarrhs, swelled tonsils, premature decay of



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teeth, rheumatism, remitting and intermittent fevers including ague, mild and malignant typhus fever, dysentery, jaundice, inflammation of the liver, sore eyes, measles, whooping cough, mumps, smallpox and putrid sore throat, influenza, typhoid fever, the itch, worms and goiter.

Dr. Henry Manning, who began his professional career in Youngstown in 1811, wrote of the terrible inroads of ulcerative tonsillitis (diphtheria) and frequent attacks of measles, scarlet fever and whooping cough, malaria, typhoid, cholera, typhus and smallpox.

Typhus was not uncommon among pioneer Ohioans. Commonly called ship fever, it was reported along the Ohio River and the Lake Erie areas, but made its way into other sections of the state as well. The lay literature reports an outbreak of typhus among the troops at Franklinton (Columbus area) during the War of 1812.

Many historical reports from all parts of Ohio mention typhoid as a leading illness, and local epidemics of the disease were common. In fact, typhoid was until recently a public health problem in Ohio with occasional isolated outbreaks.

Background Readings

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Corlett WH: Medicine in Ohio before the advent of the white man. Ohio State Med J 32:45-71, 1936.

Drake D: A Systematic Treatise, Historical, Etiological and Practical, on the Principal Diseases of the Interior Valley of North America, Cincinnati, Winthrop B Smith & Co, 1850

Dittrick H: Medical agents and equipment used in the Northwest Territory (pts 1 and 2). Ohio State Med J 48:622-625, 735-738, 1952.

Forman J: Cholera infantum. Ohio State Med J 42:50-51, 1946.

Hudson, NP: Yellow fever in Ohio. Ohio State Med J 61: 1054-1055, 1965.

Jordan, PD: Milksickness in the western country together with an account of the death of Lincoln's mother. Ohio State Med J 40:848-851, 1944.

McCurdy, SM: A successful medical career on the Western Reserve. Ohio State Med J 32:855-858, 1936.

Mitchell EW: Cholera in Cincinnati. Ohio State Med J 33: 69-70, 1937.

Mitchell EW: Yellow fever in Cincinnati. Ohio State Med J 33:184-185, 1937.

Sharkey TP: The management of malaria. Ohio State Med J 42:1025-1034, 1946.

Williams SR: A localized outbreak of Asiatic cholera in 1834. Ohio State Med J 39-1029-1031, 1943.

Mr. Moore was the Executive Editor and Executive Business Manager of *The Ohio State Medical Journal* for 26 years prior to his retirement in October 1974.

proceedings of the council

A regular meeting of the Council of the Ohio State Medical Association was held Saturday and Sunday, September 20-21, 1975, at the OSMA Headquarters' office, 600 South High Street, Columbus, Ohio.

Those present Saturday were: All members of the Council (with the exception of J. Hutchison Williams, M.D.); Mr. James E. Pohlman, Esq., Columbus, OSMA Legal Counsel; P. John Robechek, M.D., Cleveland, Chairman, Ohio Delegation to the American Medical Association; John H. Budd, M.D., Cleveland, Member of the AMA Board of Trustees; Mr. Richard G. Layton, Director, AMA Field Service Department; Mr. D. Mark Mahler, Ohio State University American Medical Student Association Representative; and Messrs. Page, Edgar, Campbell, Clinger, Rader, Houser, Mulgrew, Holcomb, Freeman, Mrs. Wisse, Mrs. Dodson and Mrs. Tanner, of the OSMA Staff.

Those present Sunday were: All members of the Council (with the exception of Drs. Stephen P. Hogg, John C. Smithson, J. Hutchison Williams and Robert G. Thomas); James C. McLarnan, M.D., Mt. Vernon; Mr. Pohlman, Dr. Robechek, Dr. Budd, Mr. Mahler, and Messrs. Page, Edgar, Campbell, Clinger, Rader, Houser, Mulgrew, Holcomb, Freeman and Mrs. Wisse, of the OSMA Staff.

The meeting was called to order by President

The minutes of the July 12-13, 1975, meeting of the Council were approved.

Membership

The membership report was presented by Mr. Page, and was accepted for information. Ohio State Medical Association membership showed a net gain of 178 on September 12, as compared to the same date in 1974.

Dr. Pichette requested an analysis with regard to the percentage of those entering practice for the first time who affiliate with their county medical societies and the Ohio State Medical Association.

Fiscal Matters

The minutes of the Committee on Auditing and Appropriations meeting, held September 19, 1975, were presented by Dr. Thomas, and were adopted.

American Medical Association

Dr. P. John Robechek, Chairman of the Ohio Delegation to the AMA, reported on the delegation's plans for the conduct of the campaign to elect Dr. John Budd, President-Elect of the American Medical Association, at the Dallas meeting in June.

Mr. Campbell reported on the plans for the Clinical Session, to be held in Honolulu, Hawaii, November 29-

December 3.

AMA Field Service Director

Richard G. Layton, Director of the Field Service Department of the American Medical Association, was introduced by Dr. Lieber. Mr. Layton presented a report on the professional liability problem as it presently exists in the various states and reported on the formation of the American Medical Assurance Company by the AMA to provide re-insurance for state professional liability insurance plans.

Mr. Layton then answered a number of questions with regard to the general activities of the American Medical Association, including a request for information on the new corporate structure of the AMA staff.

OSMA Annual Meeting

Mrs. Dodson announced that as a result of a site survey by the American Medical Association's Council on Medical Education of the OSMA Annual Meeting and the activities of the Committee on Scientific Work, the Ohio State Medical Association has been given full approval and accreditation for continuing medical education activities without "recommendations" (qualifications) for four years. Mrs. Dodson explained that this means that the Committee on Scientific Work can conduct programs which will provide "Category I" credit to participants retroactive to the 1975 Annual Meeting.

President Lieber congratulated Mrs. Dodson and the Committee on Scientific Work on this accomplish-

The Council then approved a request from the American Medical Association involving the co-sponsorship of an American Medical Association Regional Continuing Medical Education meeting in Ohio in 1977.

Mrs. Dodson then reviewed the meeting of the Committee on Scientific Work with Ohio Specialty Societies and Sections on August 20, 1975.

The minutes of the Committee on Scientific Work meeting, held August 21, 1975, were presented by Mrs. Dodson, along with the Annual Meeting schedule for 1976. Both were approved.

MAI/Peer Review Systems

Dr. Henry reported on the activities of Medical Advances Institute/Peer Review Systems. Action on the proposal with regard to the formation of the Ohio Health Data Corporation was deferred pending receipt of recommendations from the attorneys with regard to the composition of the Board of Directors.

Ohio Medical Indemnity, Inc.

State and national Blue Shield activities were reviewed by Mr. Page.

(continued on page 811)



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proceedings of the council

Ohio Foundation for Medical Care

The minutes of the meeting of the Board of Directors of the Ohio Foundation for Medical Care, September 3, were presented by Mr. Holcomb. The report was accepted for information.

Committee Reports

Committee on Emergency and Disaster Medical Care

The minutes of the September 13 meeting of the Committee on Emergency and Disaster Medical Care were presented by Mr. Houser. The minutes were approved with the exception that a recommendation with regard to emergency medical information cards was returned to the committee for further study.

Committee on Workmen's Compensation

The minutes of the September 10 meeting of the Committee on Workmen's Compensation were presented by Mr. Campbell, and were accepted.

Council Fee Review Committee

The minutes of the Council Fee Review Committee meeting of September 19, 1975, were presented by Dr. Rinderknecht and Mr. Campbell, and were approved.

By official action, Dr. Lieber added Dr. Thomas W. Morgan, to the Council Fee Review Committee.

Physician Effectiveness Subcommittee

Mr. Clinger delivered a progress report on the Physician Effectiveness Subcommittee. The report was accepted for information.

Commission on Medical Education

The minutes of the September 11 meeting of the Commission on Medical Education were presented by Mr. Houser. The Council approved the Commission's proposal with regard to the application form for the 1975 Physician's Recognition Award.

The Council approved the publication of a continuing medical education diary, which will be mailed to the members of the Ohio State Medical Association

in an appropriate issue of the OSMAgram.

With regard to the accreditation of continuing medical education courses, the Council modified and adopted the statement that the OSMA encourage the formation of consortia under the aegis of the county medical society where possible, and other cooperative arrangements for continuing medical education purposes.

The Council approved the Commission proposal that OSMA use the same continuing medical education categories as the AMA, and adopted a recommendation that the Commission proceed with dispatch in reconstructing the OSMA program so that it is compatible with that of the American Medical Association.

It was pointed out that in general terms, the accreditation of institutions for the presentation of AMA approved credits is in the realm of the Commission on Medical Education.

The AMA Council on Medical Education has accredited the Ohio State Medical Association, so that it can give Category I credit for its programs. In order that there will be control and a uniform approach to determine which programs meet the criteria of Category I, the Committee on Scientific Work will determine what sponsored or co-sponsored activities of OSMA will be so designated.

Other Meetings

The following meetings were reviewed for the information of the Council: State Planning Committee for Health Education in Ohio, July 29—Mr. Clinger; Association of County Medical Executives, August 3-5—Mr. Holcomb; Joint Meeting of the Officers of the Ohio Hospital Association, Ohio Osteopathic Association for Physicians and Surgeons and the Ohio State Medical Association, August 6—Dr. Lieber; Meeting with regard to Anti-substitution Repeal Proposals involving Rupert Salisbury, Dr. Chewning and Mr. Edgar, August 6—Mr. Edgar, and the Ohio Health Commissioners Conference, September 10—Dr. Lieber.

Councilor Reports

The Councilors reported on various activities in their respective districts, and discussed grievance and malpractice reports in these districts.

Federal Legislation

Mr. Edgar presented a report from the American Society of Association Executives on House Resolution 1040. The Council voted its opposition to the bill and directed Mr. Edgar to send a message to Congressman Clancy, expressing this opposition.

Mr. Edgar announced that national health insurance hearings will begin in the House Ways and Means Committee, September 28, and last through the

remainder of 1975.

State Legislation

The state legislative report was presented by Messrs. Rader and Mulgrew.

S.B. 363, "hospital patient's bill of rights"—received for information and study.

Sub. S.B. 183, repeal of anti-substitution laws and establishment of a formulary—active opposition.

H.B. 1000, requires hospitals to offer pap tests to all females—received for information and study.

H.B. 244, to establish commitment procedures for the mentally ill. The Council voted to support the bill, if the following amendments are adopted: (1) amendment to maintain confidential relationship between patient and physician; (2) amendment to maintain consultative relationship between physician and psychologist (psychologists cannot be allowed to stand alone and

proceedings of the council

make decisions with possible medical implications).

H.B. 296, HMO bill; H.B. 432, optometry bill; H.B. 663, physician's assistants bill, were discussed for information purposes.

The four issues recommended by Governor Rhodes for the improvement of the economical status of Ohio were discussed by the Council and were endorsed.

Constitution and Bylaws

Amendments to the Constitution and Bylaws of the Lawrence County Medical Society were approved as submitted.

Amendments to the Constitution and Bylaws of the Academy of Medicine of Cleveland and Cuyahoga County were approved as submitted.

Legal Counsel Report

The report of the legal counsel was accepted for information.

Field Service Report

The report of the Field Service Department was presented by Mr. Holcomb, and was accepted for information.

Professional Liability Activities

The President announced the following four physicians have been recommended by OSMA for membership on the Medical Advisory Committee to the Joint Underwriting Authority: C. Douglass Ford, M.D., Toledo; H. William Porterfield, M.D., Columbus; Eugene J. Burns, M.D., Cincinnati and Nicholas G. DePiero, M.D., Cleveland.

Mr. Campbell reported, as of September 18, 1,243 applications have been filed for insurance through the Joint Underwriting Authority and that 801 individual physicians and corporations had been covered.

Dr. Pichette called attention to a resolution from the Mahoning County Medical Society, commending the officers and staff for their untiring efforts in behalf of the physicians of Ohio, which resulted in the timely passage of the Omnibus Malpractice Bill.

Cooperative Health Statistics System

Mr. Page reported on the Cooperative Health Statistics System survey now being conducted in a number of states by the Division of Health Manpower

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(continued from page 812)

and Facilities Statistics, of the National Center for Health Statistics (NCHS).

Rural Health Conference

A proposal that Columbus be selected as the site for a future AMA Rural Health Conference was approved.

OSMA Major Medical Plan

The Council studied various proposals for change in the OSMA Membership Major Medical Plan, due to the fact the present premiums are not sufficient to cover the Plan's operations.

The Council **approved** "Option B," which would include coordination of benefits, premium increase and the opportunity to apply for coverage up to \$250,000.00.

The Ohio State Medical Journal

The Council approved Mrs. Tanner's recommendation that United Media Associates, Inc. (UMA) be engaged as The Journal's advertising representative, in lieu of the State Medical Journal Advertising Bureau (SMJAB).

Mrs. Tanner announced that she would be leaving her position due to the fact that her husband has accepted a position on the faculty of the Dental School of the University of North Carolina, and that her replacement has been selected and would be trained during the next four weeks.

Dr. Lieber expressed thanks to Mrs. Tanner for her outstanding work and the regret that she is leaving the Association staff.

Committee With Psychologists

The Council approved the concept of a Joint Conference Committee on Mental Health, involving the Committee on Mental Health of the Ohio State Medical Association, officers of the Ohio Psychiatric Association and of the Ohio Psychological Association.

Gallipolis State Institute

The Council received a letter from Dr. Timothy B. Moritz, Director of the Ohio Department of Mental Health and Mental Retardation, asking for assistance with an investigation of medical practice at the Gallipolis State Institute. It was announced that Dr. Milton M. Parker, Chairman of the OSMA Committee on Mental Health, would represent the Association on this matter.

Future Council Meetings

Dr. Lieber announced the following dates for future meetings of the Council: November 8-9; December 13-14, and January 31-February 1.

ATTEST: Hart F. Page Executive Director

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obituaries

Warren Baird, M.D., Sylvania; Medical College of Georgia, 1930; age 70; died September 21; member of OSMA and AMA.

Joseph M. Basile, M.D., Youngstown; Universite Saint Joseph, Beirut, 1919; age 88; died September 16; member of OSMA and AMA.

Marion E. Black, M.D., Shaker Heights; University of Pennsylvania, 1934; age 67; died August 2; member of OSMA and AMA.

James I. Collins, M.D., Toledo; Loyola University, 1931; age 68; died September 10; member of OSMA and AMA.

Leroy Collins, M.D., Akron; Meharry Medical College, 1950; age 50; died September 30; member of OSMA and AMA.

Armen G. Evans, M.D., Cleveland; Western Reserve Medical School, 1920; age 80; died September 12; member of OSMA and AMA.

Benjamin S. Gillespie, M.D., Pittsburgh, formerly of Franklin County; Western Reserve Medical School, 1939; age 66; died September 21; former member of OSMA.

John D. Hathaway, M.D., Columbus; The Ohio State University College of Medicine, 1931; age 70; died September 1; member of OSMA and AMA.

Robert E. Johnson, M.D., Perrysburg; The Ohio State University College of Medicine, 1954; age 47; died September 27; member of OSMA and AMA.

Frank F. Jordon, M.D., Hudson, Western Reserve University School of Medicine, 1924; age 80; died September 16; member of OSMA and AMA.

Vemont D. Kerns, M.D., Circleville; University of Louisville, Kentucky, 1934; age 71; died September 28; member of OSMA and AMA.

J. Fred Lembright, M.D., Alliance; The Johns Hopkins School of Medicine, 1935; age 65; died September 16; member of OSMA and AMA.

Cornelius A. McGrew, M.D., Wadsworth; University of Buffalo, 1945; age 56; died September 15; member of OSMA and AMA.

Alexander Miller, M.D., Cleveland; Western Reserve University School of Medicine, 1926; age 73; died September 15; member of OSMA and AMA.



Following are names of new members of the Ohio State Medical Association certified to the headquarters office during September, 1975. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

Columbiana (East Liverpool)

George P. Naum Cuyahoga (Cleveland) Thomas W. Brown John B. Mesic Jose Pozuelo-Utanda C. Robert Wolff Defiance (Defiance) Joseph A. DiPasquale Robert J. Foldvary Franklin (Columbus, except

where noted) Francisco T. Aledia Robert W. Almoney, Jr. William T. Bronson, Jr. William J. Holaday Jack M. Lomano Westerville Eugene S. May Gerald M. Penn

Robert L. Thompson Frederick P. Zuspan Hamilton (Cincinnati) William A. Bramlage

Arthur J. Canos William Chang

Thomas F. Craven Harry M. Davin Baher S. I. Foad Michel Susan Foster Deborah A. Goodlander John A. Halpin Adelheid K. Kahn Joseph C. Russell R. N. Shenai Raghu R. Singh Jack Sobel Howard H. Sokolov Galen R. Warren

Licking (Newark) Jack L. Kane John J. Winsch

Marion (Marion) Lee Johnson Saeeda Mobin-Uddin

Montgomery (Dayton) Barbara A. Pflum

Richland (Mansfield) Dennis A. Young

Seneca (Carey) Cecilio V. Delgra

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Carl Schurz, U.S. statesman and journalist in the late 1800's, said: "Ideals are like stars. You will not succeed in touching them with your hands, but like the sea-faring men on the desert of water, you choose them as your guides, and following them you will reach your destiny." Certainly in auxiliary work, ideals mean pursuing them, not just dreaming about them. Following ideals maintains constancy of purpose. For auxiliary projects to be successful, we must pursue those ideals with enthusiasm and a sense of dedication to the medical profession and to the community in which we live.

If you'll forgive the play on words, the OSMA auxiliary came up with an ideal series on Fall Conference this year, thanks to the ingenuity of state president, Mrs. Robert E. Krone, and state president-elect, Mrs. William Myers. The response on the part of the county auxiliaries was tremendous. Whether it was in the central part of the state (at Delaware) or the eastern part of the state (at New Philadelphia) or the western part of the state (at Wapakoneta), there was excellent representation from the counties.

Each conference was divided into small groups in the mornings for "round table" discussions that ran the gamut from a group's greatest success to its greatest flop. It touched on the all-important question of the help a county auxiliary receives from the national and state auxiliaries. It delved into the problems and the needs of the auxiliary at the grass roots level. It was a wonderful opportunity for the local leaders to have their say, express their thoughts and ask their questions. The afternoon found the whole group in session together, asking more questions of the panel of state board members and discussing phases of particular activities. There was excellent "give and take." There was rapport. There was togetherness, not only in the sense of purpose but in the

warm bond of friendship. An "ideal" set-up, wouldn't you say??

Here and There

The Franklin County Auxiliary held its September meeting at the Fawcett Center for Tomorrow. Mrs. James L. Best, president, presided. Dr. Jack Tetirick, presidentelect of the Columbus Academy of Medicine, and David Rader of OSMA, spoke on the Malpractice Dilemma. Following the informative talks, there was a lengthy question and answer period. Mrs. Richard T. Messick, community service chairman, announced a new survey form that all members are being asked to fill out, detailing the number of volunteer hours on a weekly or monthly basis such members may be giving to community service organizations. She discussed two forthcoming projects. A tutoring program is planned for first through sixth grade, for students from the 2nd Avenue area, from 3:30 to 5:30 on Monday and Wednesday afternoons or on Saturday mornings. The auxiliary member will pick up the child once a week at the youngster's home, take him or her to the Second Avenue Presbyterian Church, and tutor that child there for one school year. Group visitation to nursing homes was another project. Sounds like two great "ideals"!

Hamilton County has a star-studded activity in its Junior High School Awareness program. The program has been, and continues to be, an effective way of reaching young people with information about health careers. It is presented in individual schools upon request to acquaint the students with the many and varied health fields. It is co-sponsored by the Hamilton auxiliary and the Health Careers Association of Cincinnati. This has been a most successful project, having been shown to

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Student nurses were the honored guests at the September meeting of the Jefferson County Auxiliary. These girls benefit from the group's Loan Scholarship Fund. The luncheon meeting was held at the home of the president, Mrs. J. J. Macedonia. A few months ago, the Jefferson auixiliary participated in the "We Care Fair" by staffing a booth to distribute leaflets for the newly organized Jefferson County Committee on the Employment of the Handicapped. Mrs. William B. Mikita served as chairman. The literature stressed the need for removal of architectural barriers for the handicapped. The film shown at the fair, "Beating the Averages" (narrated by Raymond Burr), was purchased from the auxiliary's general fund. It will be shown further to city council, service organizations and any other interested groups.

Five girls from Lake County received \$400 scholarships each from the county auxiliary. The scholarships are given on the basis of grades and need. The recipients were: Mary Welsh, Donna Perry, Monica Keil, Sue

Klingman and Cheryl Davis.

Study Groups

Would you believe that the Lucas County Auxiliary, in addition to its outstanding community activities, has 16 study groups in which members may take part? Groups meet weekly or monthly, depending upon the type of class and the needs of the individuals involved, and meetings are held in the homes of members. The study group project is no new undertaking for Lucas auxiliary, but I do believe (my apologies if I'm wrong!) it is Lucas' largest study group program ever. The purpose of this program is to offer the auxiliary members a variety of interesting and recreational hobbies or studies for their own enjoyment. More important, the various study groups provide an opportunity for members to meet and get to know each other. Here are the subjects or activities covered: Antiques and Art Class, Art Classes, Book Beat, Bridge, Ceramic and Sculpture, Children—the Challenge, Decoupage, Exercises and Jogging, Gourmet, Needlepoint, Skating, Tennis Clinic, Yoga, Paddle Tennis and French Conversation.

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Ortho Pharmaceutical Corp808, 809, 810
The Park Plaza Hotel818
Pharmaceutical Manufacturers Association
Roche Laboratories, Div. of Hoffman- LaRoche, IncInside Front Cover, 753, 772, 773, Inside Back Cover, Back Cover
Roerig & Co., Div. of Pfizer771
Searle Laboratories, Div. of G.D. Searle & Co
SK & F Co., Subsidiary of Smith, Kline & French Laboratories761
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839

846

868

Clinical and Scientific Articles

CARDIAC ARRHYTHMIAS DURING TONSILLECTOMY AND ADENOIDECTOMY

Ramon Rodriguez-Torres, M.D., Toledo; Abraham Lapidot, M.D., Brooklyn, N.Y.; Hung I. Chen, M.D., Brooklyn, N.Y.; and Mansureh Paydar, M.D., Brooklyn, N.Y.

ANEURYSMAL BONE CYST OF THE FIRST LUMBAR PEDICLE 843 Edward J. Kosnik, M.D., Lutherville, Md.; Peter V. Scoles, M.D., Columbus; and Martin P. Sayers, M.D., Columbus

MATERNAL HEALTH IN OHIO: MATERNAL DEATHS INVOLVING LOWER NEPHRON NEPHROSIS

By the OSMA Committee on Maternal Health

Special Articles

A NEW FEATURE: CROSSING COUNTY LINES 832 REPORT ON IMPLEMENTATION OF AMENDED RESOLUTION 7-75 852 HISTORIAN'S NOTEBOOK:

HISTORY OF A SUCCESSFUL CASE OF CESAREAN OPERATION John L. Richmond, M.D.

STATE MEDICAL BOARD ISSUES ACTIVITY REPORT FOR 1974 871 OSMA OFFICERS, COUNCILORS, AND EXECUTIVE STAFF 873 887 OSM JOURNAL INDEX FOR VOLUME 71

Teatures News	849	Woman's Auxiliary	874
Comments	834	Continuing Education	857
Ohio Health News	864	Obituaries	855
Crossing County Lines	832	Journal Advertisers	891
New Members	863	Classified Ads	892

COVER: The medallion pictured on the cover and also in the Maternal Health headline hangs in the office of Anthony J. Ruppersberg, Jr., M.D., of Co!umbus. Dr. Ruppersburg, Chairman of the OSMA Committee on Maternal Health, rescued the plaster medallion from a scrap heap in the 1940s and has since restored it.



AMA Past-President Malcolm Todd Speaks Out At Columbus Academy Dinner

Recently, the Academy of Medicine of Columbus and Franklin County hosted Malcolm C. Todd, M.D., Past-President of the AMA. Dr. Todd, who became President of the AMA in 1974, has long served the medical community. He has been President of the California Medical Association (1967-1968), California Delegate to the AMA (1959-1973), and chairman of the AMA delegation which visited the People's Republic of China in 1974.

Dr. Todd has devoted his energies toward improving the quality of life of the American people and urging physicians to place greater emphasis on the human and social side of medicine. During his time in Columbus, Dr. Todd spoke out on a number of issues. His remarks are capsulated as follows:

AMA MEMBERSHIP

The AMA has more members today than ever before. The recent financial problems of the organization have been alleviated by 140,000 members having paid the \$60 special assessment at October's close.

AMA RESPONSIBILITY

The AMA must demonstrate leadership. As the nation moves toward (what Dr. Todd calls) the fourth branch of government, the regulatory branch, doctors must strive for the best laws possible.

CONTINUING MEDICAL EDUCATION

Congratulations to OSMA for its efforts in this area. Priority for continuing medical education is necessary to avoid federal relicensure. Medicine has been more successful than any other profession in up-grading the quality of its members. Last year, 3,259 courses were offered nationwide. It is essential, however, that all doctors participate.

HEALTH CARE COST

The world's best health care can be found in the United States, but it is also the most expensive. The chief factors affecting the rising cost of health care are infla-

tion, labor cost in hospitals, and malpractice cost reflected in higher fee and room rates. Physicians can battle the rising cost by making pre-hospital-admission testing more routine and by encouraging cost accounting in hospitals. Doctors should also keep the competitive spirit of hospitals at a realistic level so that all do not feel that they must have the same comprehensive and expensive facilities.

MEDICAL LIABILITY CRISIS

The medical liability crisis is nationwide. It is being caused by an increasing number of suits, the escalation of monetary awards and the resulting decrease in liability carriers. The crisis should be handled at the state level; the Ohio bill deserves commendation. Components that must be handled include a reasonable statute of limitations, a ceiling on the amount of an award, consideration of collateral sources of income in granting an award, a review of informed consent, and resolution of the contingent fee situation.

The American people must be educated to understand that every case of a bad result is not a case of malpractice. There is risk inherent in modern medicine and physicians cannot guarantee results.

Physicians, on the other hand, must strive to keep errors to a minimum. This can be accomplished by a yearly check of credentials and by willingness to revoke the license of an unqualified doctor. Physicians must also "practice the art of medicine not only the science." The better the doctor-patient relationship, the more respect the patient will have for his physician. This should lead to a lessened desire to file suit against a physician.

"How good is a doctor if he treats the patient as aloofly and materialistically as a piece of tickertape? How good is he if he leaves him in the frightening dark about his diagnosis, prognosis, and the reasons for the size of the bill?"

NATIONAL HEALTH INSURANCE

The AMA's bill now before Congress would do more and be less inflationary than any other bill proposed. Some form of catastrophic protection is necessary, especially for those earning between \$8,000 and \$10,000.

PHYSICIAN SHORTAGE

The United States has enough physicians. The problem is not the number of physicians but the geographic distribution and the over-abundance of specialists. The nation needs more physicians entering areas of primary care.

Toledo Hosts Arbitration Forum

The Academy of Medicine of Toledo and Lucas County sponsored a medical malpractice arbitration forum during November. The program was spearheaded by C. Douglass Ford, M.D., OSMA Councilor from the Fourth District, and chaired by George N. Bates, M.D., President-Elect of OSMA.

Featured on the program were Arnold F. Bunge. Jr., Robert G. Clayton, Jr., and William M. Connelly, lawyers from the Toledo area. These men reviewed aspects of H.B. 682, the omnibus malpractice bill. It was emphasized that any physician who receives notice that someone is considering malpractice action against him should immediately pass this fact on to his liability carrier.

The American Arbitration Association was represented by Philip Thompson, Regional Director from Cincinnati, Earl Brown, Regional Director from Cleveland, and Richard Lerner, attorney for the association.

Mr. Thompson explained that an arbitration procedure is much like a court case in that opening statements, examination and cross-examination of witnesses, and the like come into play. Should the matter proceed from an arbitration panel decision into the courts, the jury can be instructed as to the decision of the panel.

The highlight of the evening was the talk by Richard Lerner. He finds it strange that legislative committees on insurance are brought into the malpractice problem with much greater frequency than committees on health care. He feels that the malpractice issue is a health care crisis not an insurance crisis.



Robert E. Holcomb, OSMA Field Services Director, Douglas Freeman, Associate Field Services Director, and John A. Devany, M.D., President of the Academy of Medicine of Toledo and Lucas County, attended the Arbitration Forum.



The forum, held at the College of Law of the University of Toledo, informed both lawyers and physicians.

"If it is a health care crisis, what a meritoriously injured claimant needs is not money so much but the guaranteed assurance of future health care," said Mr.

He noted that although only five states have legislated on arbitration in 1975 (Alabama, California, Louisiana, Michigan and Ohio), arbitration is not new. A notable example is its use in the prepaid group context in the Ross-Loose medical plan in California. It has been in use there since the early 1920s. A participant in this medical program must agree to binding arbitration before any treatment is provided.

Arbitration has a variety of advantages over litigation. Included are the ability to hold the panel in any convenient setting, a minimum of pretrial publicity, and more candor due to a more relaxed atmosphere.

Rumor to the contrary, Mr. Lerner has yet to see that arbitration awards in comparable settings yield fewer dollars to fewer meritoriously injured claimants than does litigation.

Mr. Lerner feels that arbitration may help liability insurance premiums stabilize but not reduce. He has seen nothing reduce in cost in the past years.

Finally, Mr. Lerner issued a strong warning to the attorneys present. He said, "We attorneys must watch the medical malpractice crisis situation very carefully because we are standing right behind them. When you go out to practice and you have to buy your professional liability insurance, beware. The same symptoms that attach to the physicians today, attach to the attorneys tomorrow. . . . So listen with care because the prescriptions offered the physicians today, the attorneys will be seeking tomorrow.

(continued on page 837)

comments

Quo Vadis Tuberculosis?

Almighty God's greatest and most precions gift to man—his brain—has been used through history for his long survival, as well as self-destruction. Thousands of lives have been destroyed during my lifetime by modern war weapons during the Second World War, the Korean War, and the Viet Nam War. On the other hand, thousands of lives have been saved by the great medical discoveries and advances.

I was brought up in Asia Minor, a protuding portion of Western Asia which is surrounded by the: Black Sea on the north, the Aegean Sea on the west, and the Mediterranean Sea on the south. This land is separated from the sea with mountains which form a high plateau in the middle, called Anatolia. The climate in Anatolia is cold in the winter and dry and warm in the summer. It is so dry in the summertime that the soil develops multiple cracks like dehydrated human tips. In this dry Anatolian plateau, there are scattered areas of a weak supply of underland water which surfaces, and there, men build their home and settle, farm, and raise their animals—like an oasis.

The men who moved and lived in that easis used to pay high prices to live near the water with their suffering and diseases. Small patches of still water are all mosquitoes need to lay their eggs and multiply, suck the dehydrated men's blood, and spread deadly malaria from one muon to another. For centuries, this occurred.

I remember my medical instructor's advice in my late years in medical school. He said, "Be sure to carry a syringe and several ampules of injectable quinine in your bag all the time. If you are called to a patient with fever, you don't have to perform a long examination and do tests, go ahead and give your injection of quinine. You'll be right in 98 percent of the cases with your diagnosis of malaria and your treatment." This is how widespread malaria was among men in Anatolia during the late 1940's.

When I returned to Turkey in the early 1950's I promised to send a malaria blood slide to my colleague in the United States. I could not keep my promise; in a few years, malaria had become a rarity, and was eventually eradicated. Who did it? The mighty human brain with its discovery of DDT and other insecticides along with the anti-malaria drugs.

During my residency, I was one of the first to use pneumoperatonemic (air insufflation to the abdominal cavity) to treat another deadly disease, pulmonary tuberculosis, which also was called consumption, or florid phthisis. At that time, a sick person with tuberculosis and his whole family were almost condemned in the community. Intermarriage with this family was resisted

by the public. They were isolated, separated, in sanatoriums. Then came the antibiotics, very expensive streptomycin; collapse of the lung by air—pneumothorax; by operation—thoracoplasty; by various types of plastic materials—plombage; by early pulmonary resection for treatment of tuberculosis—plurenic nerve crush.

Now, all these are historical medical terms. Then came several other antituberclotic drugs. Sanatoriums closed and tuberculosis became a rare disease.

During the International Conference on Lung Disease at Montreal, sponsored by the American and Canadian Thoracic Societies in May 1975, it was emphasized and over-emphasized that tuberculosis should be considered as other low-grade infectious diseases. It can be treated in general hospitals by general practitioners, internists, and followed by out-patient departments, at doctor's offices, provided that these physicians are informed about diagnosis, treatment, and prophylaxis of tuberculosis. How do we do that?

According to the new simplified classification of tuberculosis, each man falls in one of four basic categories.

Category O. Person has no tuberculosis exposure; no infection. These are the people who have no history of exposure to an infectious case of tuberculosis and they have a negative skin test, For these people, no medication, no prophylaxis, and no surveillance is advised.

Category I, Those people who are exposed to infectious tuberculosis cases but have no evidence of infection. These people have a history of exposure to a case and have a negative skin test. They need to be protected because they have a history of being in contact with tuberculosis. If they are suitable for INH®, it should be given to these people adult dose, 300 mg per day for three mouths, and retested with tuberculin. If their skin test remains negative and contact is broken, these people can be discharged from surveillance. If their skin test becomes positive, which means these people are infected already. INH should be continued for 12 mouths. If such a person who has contact with tuberculosis caunot be treated with prophylatic INH for some reason, he should be followed for his symptoms and re-tuberculin tested in three months, at which time he may be discharged if the skin test is negative and the contact is broken.

Category II. Those persons who have been infected with tuberculosis without disease. These are the extuderculosis patients who have shown the infection by positive tuberculin skin test, negative bacteriological studies, and negative rocutgenological findings comparable with tuberculosis, and no symptoms due to tuber
(continued on page 837)

comments (continued from page 834)

culosis. These people do need prophylatic treatment with INH, 300 mg daily for one year. They can be discharged from surveillance upon completion of therapy.

Category III. Patients who have tuberculosis. Infected and sick, these people should be treated with at least two antituberculosis drugs, one of which is preferably isoniazid, for a minimum of 18 to 24 months. These people may be treated in the hospital or home. Hospitalization is usually indicated for the patients who have other disabling disease along with tuberculosis or with symptomatic tuberculosis. Otherwise, it is recommended that they be treated at home. If these people are infectious, they should be cautioned against contacting other people for about two weeks. During that time, they should take precautions to cover their mouth when they are coughing, and to have a good exhaust ventilation of their rooms.

If their physical condition permits, they may return to their work in two or four weeks. All their contacts prior to the diagnosis should be treated as Category I or II. Choice of drugs should be at the discretion of their treating physician according to the patient's condition and drug toxicities.

I am proud of the scientists of my generation who found the treatment and remedies for many human sufferings. But there remains a lot more to be solved. As the French say, "Qui n'a santé n'a rien" which means "He who lacks health, lacks everything."

-S. Solu, M.D.

Dr. Solu, of Kent, is Medical Director, Lorain County TB & Chest Clinic; Clinical Instructor in Pulmonary Disease, Case Western Reserve University Hospital; Chief of Emergency Department, Robinson Memorial Hospital.

County Lines (continued from page 833)

Medina County Medical Society Honors State Legislator

Recently the Medina County Medical Society honored State Representative William G. Batchelder for his active role in designing and promoting H.B. 682, the omnibus malpractice bill. Representative Batchelder's district includes the Medina County area.

Hart F. Page, OSMA Executive Director, presented a plaque to Representative Batchelder on behalf of Medina County physicians.

The meeting also included a panel discussion concerning plans for the future with respect to liability legislation. Participants were Representative Batchelder, David L. Rader, Director of State Legislation at OSMA, and Mr. Page.

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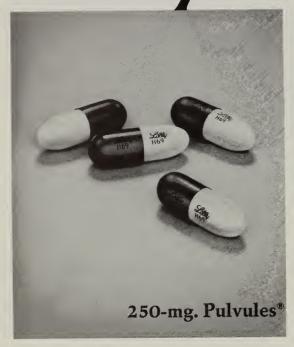
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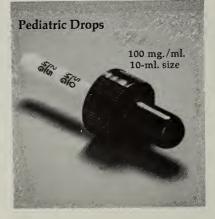
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Cardiac Arrhythmias During Tonsillectomy and Adenoidectomy

Ramon Rodriguez-Torres, M.D. Abraham Lapidot, M.D. Hung I. Chen, M.D. Mansureh Paydar, M.D.

This study was conducted to determine if significant electrocardiographic disturbances, particularly arrhythmias, occur in patients during tonsillectomy and adenoidectomy.

Twenty-one patients who required tonsillectomy and adenoidectomy were selected. Ninety percent of the patients developed sinus tachycardia, atrioventricular junctional arrhythmias, sinus bradycardia, wandering atrial pacemaker, and S-T wave changes. Most of these changes continued through the entire surgical intervention.

These arrhythmias may not relate directly to the operative procedure since there are many other factors which can cause them. We concluded by recommending higher oxygen concentration, frequent bagging, gentle operative technique, and continuous monitoring of these patients during the removal of the tonsils and adenoids.

PREVIOUS STUDIES HAVE shown that electrocardiographic changes occur during anesthesia, 1,2 intratracheal suctioning, 3 endotracheal intubation, 4 and following extubation. 5 In many patients, the arrhythmia was attributed to anoxia and/or hypercapnia. Other investigators confirmed the view that stimulation of the autonomic nervous system plays a significant role in the genesis of these arrhythmias. 6 This study was conducted to determine if significant electrocardiographic distur-

bances, particularly arrhythmias, occur in patients during tonsillectomy and adenoidectomy.

Method

Twenty-one patients who required tonsillectomy and adenoidectomy were selected for this study. Seventeen children whose ages ranged from 3½ to 13 years (mean of 51/2 years), of whom 13 were female and four males, and four adults whose ages ranged from 19 to 30 years (mean of 24½) were studied. One patient had a history of febrile convulsions and another of bronchial asthma. Two of the adult cases had had rheumatic fever without evidence of carditis. Preoperative evaluation of all the patients before and after the surgical procedure consisted of complete physical examination, 12-lead electrocardiogram, chest radiographs, and lead-II ECG monitoring during the entire procedure. The pediatric patients were given general inhalation anesthesia of 1-2.5 percent halothane, 66 percent nitrous oxide, and 33 percent oxygen. The adult patients were operated on under local anes-

Dr. Lapidot was Chief, Division of Otolaryngology and Drs. Chen and Paydar were Fellows in Pediatric Cardiology, Downstate Medical Center, State University of New York, Brooklyn, N.Y., at the time this study was made.

Submitted May 6, 1975.

Dr. Rodriguez-Torres, Toledo, Chief of Pediatrics, Medical College of Ohio Hospital; Professor and Chairman, Department of Pediatrics, Medical College of Ohio at Toledo; and former Professor and Acting Chairman, Department of Pediatrics, Downstate Medical Center, State University of New York, Brooklyn, N.Y.

Dr. Lapidot was Chief, Division of Otolaryngology and Drs.

thesia using 2 percent Xylocaine® plus 1/1000 epinephrine after topical 5 percent Cyclaine® was sprayed in the pharynx. All patients were premedicated with atropine, Demerol®, or Nembutal®.

Results

None of the patients had abnormalities on physical examination. Nonorganic heart murmurs were present in 53 percent of the pediatric patients. Chest radiographs showed normal cardiothoracic ratio and pulmonary circulation. The electrocardiograms before the operation were all within normal limits. There was a high incidence of sinus arrhythmia (64.7 percent) in the pediatric patients (Fig. 1). The most common arrhythmia was sinus tachycardia, and it occurred in 69.6 percent of these patients. Atrioventricular junctional arrhythmias were present in 22.8 percent of the patients during the induction of anesthesia. Five pediatric patients showed ST-segment and T-wave changes with either slightly depressed STsegment or T-wave flattening. All adult patients but one had nonspecific ST-T wave changes as well. One of the pediatric patients had very interesting electrocardiographic findings (Fig. 2). She developed atrioventricular junctional rhythm with intermittent regular sinus rhythm which commenced during induction of anesthesia and

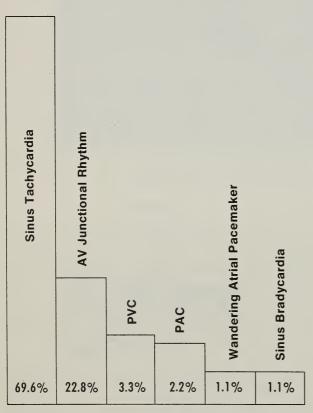


Fig. 1. Percentage of different arrhythmias observed during the procedure.

persisted through the adenoidectomy and left tonsillectomy. At the time of right tonsillectomy, she developed bigeminy and premature atrial contractions with aberrant ventricular conduction. This rhythm continued postoperatively. It improved by increasing oxygen concentration through positive pressure breathing. A few patients had atrioventricular junctional rhythm during anesthesia induction and intubation, which disappeared on positive bagging with oxygen but reappeared with less bagging or no bagging. One adult patient had occasional premature ventricular contractions before anesthesia, which disappeared after local anesthesia but reappeared postoperatively.

The incidence of cardiac arrhythmias during the procedure of tonsillectomy and adenoidectomy (Fig. 3) showed 28.6 percent of the patients with sinus tachycardia which occurred during induction of anesthesia and intubation. All the patients, with the exception of two, developed cardiac arrhythmia (90 percent), sinus tachycardia, atrioventricular junctional arrhythmias, sinus bradycardia, wandering atrial pacemaker, and ST-T wave changes. Most of these changes continued through the entire operative procedure. Fifty-three percent of the patients demonstrated cardiac arrhythmia during adenoidectomy, 62 percent during left tonsillectomy, 66.7 percent during right tonsillectomy and 66.7 percent upon extubation and immediately after the procedure. Twentyeight percent of the patients continued to have sinus tachycardia for a further period of 24 hours after the operation. Premature ventricular contractions (PVC) reappeared in one adult patient who had this condition before the operation.

Discussion

The incidence of cardiac arrhythmias related to nasopharyngeal and upper airway stimulation has been shown previously.⁷ In the series by Chang, et al,³ cardiac arrhythmia resulting from tracheal suctioning was present in 35 percent with a range of 21 to 68 percent. In the

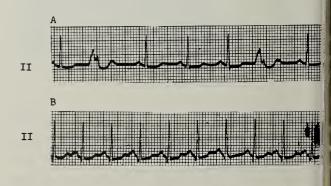


Fig. 2. Standard ECG lead II of pediatric patient (A) during induction of anesthesia and left tonsillectomy and adenoidectomy, and (B) at time of right tonsillectomy.

series of Hutchinson,⁵ arrhythmias following extubation was 18.6 percent. Burstein's series of endotracheal intubation produced arrhythmias in 24 percent.⁴ The incidence of cardiac arrhythmias in our study could not be compared with other studies because of difference in methodology. Our patients showed 28.6 percent sinus tachycardia in the operating room before anesthesia began. During the induction of anesthesia and endotracheal intubation, 90 percent of the patients demonstrated different types of arrhythmias. Russell observed 660 episodes of arrhythmia in the operating room in 3,177 adult patients who underwent different types of surgery.1 The most common arrhythmias were premature ventricular contraction, sinus bradycardia, sinus tachycardia, and nodal rhythm. Whereas, in our pediatric patients, sinus tachycardia, atrioventricular junctional rhythm, and premature atrial contraction were the most common findings. Our four adult patients developed sinus tachycardia and ST-T wave changes during operation. The pediatric patient developed frequent atrioventricular junctional rhythm during induction of anesthesia, and bigeminal premature atrial contraction (PAC) with aberrant ventricular conduction during right tonsillectomy and in the postoperative period. The arrhythmia improved with oxygen and bagging. It probably was not due to the effect of the local mechanical stimulation but, rather, to the

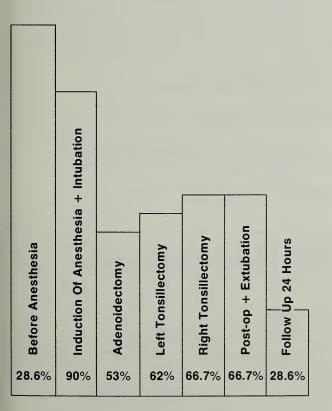


Fig. 3. Percentage of arrhythmia during different phases of tonsillectomy and adenoidectomy.

anesthesia, hypoxia, or hypercapnia. The fact that a high incidence of cardiac arrhythmias, which started during induction of anesthesia, continued during the entire procedure, and disappeared only with the administration of more oxygen or bagging, supports this hypothesis. An adult patient had PVC prior to surgery which disappeared during the operation and reappeared postoperatively (Fig. 4). In addition, he developed sinus tachycardia with a heart rate of 150 beats per minute during the operation. This can be explained on the basis of anxiety, and possibly the PVC disappeared due to the increased frequency of the sinus rhythm.

The genesis of cardiac arrhythmia has been studied extensively.8,9 The most important causes of arrhythmia probably are through the action of autonomic mediators. 10,11 It is generally agreed that the right vagus nerve supplies the sino-atrial node and the left vagus nerve innervates the atrioventricular nodal area of the heart, none of them supplying the ventricles. The interaction between the sympathetic and parasympathetic nervous system is extremely complex. Two major types of peripheral interactions have been described.¹² The first type is manifested as an accentuated antagonism between the two divisions, while in the second type, the peripheral components of one division are activated as a result of activity in the other; this is called reciprocal excitation. A similar interaction has been observed between the chronotropic effects of the autonomic neurotransmitters, norepinephrine and acetylcholine. Catecholamine increases the myocardial cyclic adenylic acid (AMP) level and adenyl cyclase activity. This increases the electrical activity of the autonomic cells during phase 4 of the action potential. The acetycholine has a reverse effect. Thus, the adrenergiccholinergic antagonism may be mediated through the adenyl cyclase systems which produces a significant effect on phase 4 of the action potential. Other factors, such as hypoxia, ischemia, elevated PaCO2, acidosis and high potassium level, calcium concentration, can alter the sensitivity of the automaticity of the pacemaker cells and increase the sensitivity of atrioventricular nodal and Purkinje fiber to the autonomic mediators.¹³ In our patients, the most common type of cardiac arrhythmia was

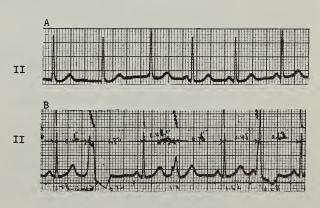


Fig. 4. Standard ECG lead II of adult patient (A) before operation, and (B) during operation.

sinus tachycardia which is due to the increase of sympathetic tone through anxiety, painful stimulation, anesthetic agents, hypoxia, and hypercapnia. The second most common type of arrhythmia was atrioventricular junctional rhythm. This can be explained by the depression of the sino-atrial fibers by the reflex liberation of acetylcholine and, due to this depression, the pacemaker shifts to the atrioventricular node. Evidently the atropine given preoperatively was not enough to counteract the action of acetylcholine. There were no special changes of cardiac arrhythmia during adenoidectomy. Right and left tonsillectomy indicated that direct local mechanical stimulation of the peripheral autonomic nervous system was not an important factor in production of arrhythmia. Although these arrhythmias may not directly relate to the operative procedure, there are many other factors which can cause arrhythmia during this common procedure in the pediatric patient. We conclude by recommending higher oxygen concentration, frequent bagging, gentle operative technique, and continuous monitoring of these patients during this procedure.

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Aneurysmal Bone Cyst of the First Lumbar Pedicle

Edward J. Kosnik, M.D. Peter V. Scoles, M.D. Martin P. Sayers, M.D.

Editor's Note: As a general rule, a case report is not the most favored type manuscript for our Journal. In this paper, the fact that the patient was male and under 10 years of age; that the symptoms were such that malignancy was suspected; and that multiple surgical procedures were necessitated amply warrant the exception to the rule. R.L.M.

A case of aneurysmal bone cyst of the first lumbar pedicle is presented. The presenting picture of rapidly progressive pain resembling the pain of bony malignancy was caused by nerve entrapment in the expanding aneurysmal cyst. Surgical resection and fusion has resulted in complete resolution of symptoms.

TAFFE AND LICHTENSTEIN^{1,2} first proposed the $oldsymbol{\mathsf{J}}$ the term "aneurysmal bone cyst" for a blood-filled lesion of bone that had previously been reported as atypical giant cell tumor, hemangioma of bone, benign bone aneurysm, and hemangiomatous bone cyst. It is an uncommon benign lesion of bone primarily affecting older children, adolescents, and young adults. Lesions of the long bones and vertebrae together account for about three-fourths of the reported cases; multiple involvement has been reported only in the spine.^{3,4} Although the radiographic appearance, microscopic features, and longterm clinical course are characteristically benign, the presenting picture may be confusing because of severe pain and rapid increase in tumor size and disability. We are presenting such a case of aneurysmal bone cyst of the first lumbar pedicle.

Case Report

A 9-year-old white boy was admitted to Children's Hospital in Columbus with the complaint of severe right flank pain. The patient had noted the onset of pain about one month prior to admission. The discomfort had reached the point of being disabling. Pain was increased with movement; improved, but not completely relieved,

by bed rest. There were no complaints of difficulty with walking or with bowel or bladder control.

Physical examination revealed a child in moderate distress with right paraspinal muscle spasm. At the level of the first lumbar vertebral body, a tender, warm, paravertebral, 6X8-cm mass was palpable. Sensorimortor examination revealed no abnormalities. There was hyperreflexia in both lower extremities. Bladder and bowel functions were normal. The only abnormality found on laboratory studies was a moderately elevated alkaline phosphatase level.

Lumbar spine films (Fig. 1) demonstrated absence of the right first lumbar pedicle with a faintly calcified mass visible. Laminography confirmed a distended calcified lesion ringed by reactive new-bone formation. Increased (99m) Tc-polyphosphate uptake was found on bone scan; results of intravenous pyelogram and inferior venacavograms were normal. Lumbar myelography demonstrated an extradural mass on the right at the level of the first lumbar pedicle.

The patient was taken to the operating room, and hemilaminectomy of the 11th and 12th thoracic and first lumbar vertebrae was performed. The lesion was found

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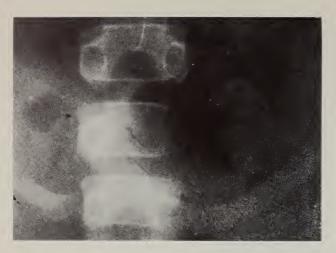


Fig. 1. Cone-down view of thoracolumbar junction. Note complete absence of L1 pedicle on right with preservation of height of vertebral body. Paraspinal calcified mass is seen also.

to involve the L1 pedicle with compression of the dura at that level. The epidural tumor was removed, decompressing the dura; it was not feasible to remove the extraspinal lesion through this approach. The epidural tumor was composed of gritty, friable, moderately vascular, greyred material; lakes of blood were not prominent; and bleeding was not excessive. The biopsy diagnosis was

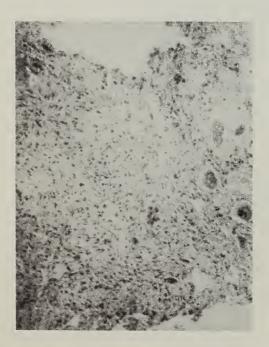


Fig 2. Photomicrograph of biopsy specimen. Higher ratio of stroma to liquid is seen in our patient.

aneurysmal bone cyst. Figure 2 is a photomicrograph of a representative area of the lesion; multinucleated giant cells, hemorrhage, and spicules of reactive new bone are found with the fibrous matrix.

The patient's pain continued postoperatively. Hamstring spasm increased, and any attempt at passive movement of the lower extremities caused severe pain. He was taken back to the operating room on tenth postoperative day, and a second-stage anterolateral exploration of the T12-L1 area through a right-flank incision was carried out. The first lumbar nerve root was found to be completely entrapped in the remaining portion of the lesion and was dissected free. Complete tumor excision and anterior fusion of the T12-L2 vertebrae were performed using the 11th and 12th ribs for graft. Postoperatively, there was complete relief of pain with no neurologic deficit.

Discussion

Many reports of aneurysmal bone cysts have been presented since the initial report by Jaffe and Lichenstein.⁵ This lesion constitutes about 2 percent of all primary tumors of bone. There is a female predominance. Children in the second decade are affected most often although a wide range of ages has been noted. The long bones are involved in about 50 percent of cases, the spinal column in 20 percent.⁴

A history of local aching pain of several months' duration is common. Although fracture through the lesion may occur, symptoms generally are the result of mass rather than fracture. In lesions affecting the spinal column, nerve root compression, cord involvement, or vertebral collapse may occur. Many spinal lesions are associated with marked muscle spasm without neurologic changes.

Most of the spinal lesions seem to start eccentrically in the vertebra, or in the pedicle or lamina. Extension into soft tissue creating a large mass lesion is seen often. This was quite evident in our patient. This lesion often mimics a highly aggressive malignancy. In this regard, our patient initially was felt to have a malignancy because of the rapid onset of symptoms and the severity of pain. His pain was the result of compression and traction on the first lumbar nerve root. Freeing the nerve resulted in relief of the patient's symptoms.

Resection and bone grafting are considered to be the treatment of choice in lesions surgically accessible. Low-dose roentgen therapy in the range of 1400 to 2000 rads has been suggested for lesions of the vertebrae.^{2,3} The hazards of irradiation of the growing spine must be carefully considered. Malignant change is said not to occur.⁷

The radiologic picture of a "ballooned-out distention of periosteum with a thin margin of new bone," described by Jaffe, is characteristic of aneurysmal bone cyst. Tomography is a useful means of determining the extent of the lesion; angiography has been employed to determine the vascular supply of spinal lesions.⁸ Rectilinear isotope scans are of questionable value in the dif-

ferential diagnosis, and are not helpful in outlining the lesion.

The gross appearance of a blood-filled cavity lined by and containing spicules of new bone is characteristic. The proportion of stroma to liquid varies throughout the lesion and from case to case. In our case, the lesion was more solid than bloody.

Microscopically, the lesion consists of lakes of nonclotted blood lined by fibrous tissue. Giant cells, hemosiderin, primitive mesenchymal tissue, and osteoid are found in varying proportion.

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Maternal Deaths Involving Lower Nephron Nephrosis

By the OSMA Committee on Maternal Health*

IN OBSTETRICS, sudden and prolonged shock due to blood loss is a rather frequent and often-unexpected complication of partruition. Generally, measures to replace blood loss by infusion of blood plasma and fluids may be successful in correcting the hypotension and other signs of hypovolemic shock. However, the damage to the renal tubules becomes irreversible and is subsequently encountered in the lag phase as tubular degeneration. Apparently the cells lining the renal tubules are highly sensitive to hypoxic changes and have relatively little capacity to recover or regenerate. The blood supply to the tubular structures is derived from postglomerular arterioles, hence, tubular necrosis is the end result of any severe diminution of renal artery blood flow.

Awareness of the threat of necrosis is essential in the early diagnosis and management of it. Early indications are oligemia, low specific gravity urine, rise in nitrogenous components in blood, hyperkalemia, and possible pulmonary edema. Prognosis for survival is relatively good in patients with *little* underlying renal disease. General

medical measures are much too detailed to be listed here; but hemodialysis or peritoneal dialysis plays an important role in therapy when spontaneous diuresis fails to occur after a four- to eight-day period of oligemia with concomitant increase in blood build-up of metabolic products. Survival statistics are difficult to obtain because of varying criteria used in reports of studies of patients who have undergone dialysis.

have undergone dialysis.

Other nonmaternal causes of tubular necrosis are those seen in crush syndrome, transfusion reaction, hemoglobinuria, overwhelming sepsis, heat stroke, and burns. In civilian hospitals, obstetric hemorrhage generally is the leading cause of acute necrosis as a sole aftermath of acute blood loss. Obstetric conditions, such as concealed hemorrhage, abruptio placentae, preeclampsia, hypofibrinogenemia, and septic abortion are the most frequent precursors of tubular degeneration. The following brief presentations are typical of the fatal sequence of events which can lead to maternal death.

*A continuous statewide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health and representatives of the various County Medical Societies. Summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published here from time to time, interspersed with statistical summaries.

A 21-year-old mother died two weeks following the stillborn delivery of her third pregnancy. Her general health was considered good; her previous pregnancies were uneventful; and present prenatal care was adequate. She was admitted to the labor room during the 39th week of gestation with tense uterus, gushing vaginal bleeding and absence of fetal heart tones. Amniotomy was performed, Pitocin drip started, and plasma given. She was delivered two hours later by elective low forceps. Heavy bleeding continued, and she was transferred immediately to a medical center in the same city for further care. She was in profound shock and was given 4 gm of fibrinogen and 6 units of whole blood immediately. Manual exploration of the uterus revealed no tissue, but the uterine walls were atonic. A uterine pack was inserted with no cessation of bleeding. Sub-total

abdominal hysterectomy was performed 30 minutes later. The patient's vital signs, fluid intake, and urinary output were fairly favorable during the first six postoperative days. On the seventh day, urinary output was 1000 cc, but the specific gravity was 1.002, and the serum potassium rose to 6.2 mEq/liter. The patient became lethargic and comatose thereafter, and blood urea nitrogen (BUN) rose to 145 mg/ml. The diagnosis of various medical consultants was renal cortical necrosis and probable pituitary necrosis, secondary to original hemorrhagic shock. All advised that hemodialysis was not indicated.

Cause of Death (Autopsy): The principal pathologic diagnoses at autopsy were listed as pituitary and lower nephron nephrosis

nephrosis.

A 37-year-old grand multipara died a week post-partum after having an emergency cesarean section performed at 34 weeks' gestation. The patient had no prenatal care. She was found unconscious on the floor by her daughter, who also noticed large amounts of blood on the clothing and called an ambulance. Upon admission to the hospital, the patient obviously was in shock with a thready pulse rate of 142 beats per minute and blood pressure of 60/30 mm Hg. The first blood transfusion was started 20 minutes after admission. Fetal heart tones were not heard, and a diagnosis of abruptio placentae was made. There was no urine in the bladder on initial catheterization. Active vaginal bleeding continued, and more blood was infused. Amniotomy was performed, but labor did not ensue and no urine was obtained from the bladder. Cesarean section was performed under light, general anesthesia with delivery of a 2.27-kg (5-lb), stillborn infant. A large volume of clotted blood was noted in the retroplacental wall. The patient continued oliguric, and fluid replacement was calculated at 500 cc plus an insensible loss. Blood chemistry and electrolytes were monitored at daily intervals. Nonprotein nitrogen level continued to rise to 102 mg/ml, one day prior to death. On the day of death, she developed acute pulmonary edema which did not respond to adequate treatment.

Cause of Death (Autopsy): The pathologist reported abrup-

tio placentae, lower nephron nephrosis, and acute left ventricular

failure as causes of death.

The third patient was a 24-year-old primipara who died two weeks after delivering a living infant at term. She registered for prenatal care at three months' gestation and had 15 visits thereafter. She was described as having a "seizure disorder," unstable personality, and low intelligence level. Her total weight gain was 29.5 kg (65 lb). She had spontaneous onset of labor and was delivered by Scanzoni maneuver under saddle block, after a two-hour stay in the labor grown. While renairing a and was delivered by Scanzoni maneuver under saddle block, after a two-hour stay in the labor room. While repairing a median episiotomy, profuse vaginal bleeding was noted. Uterine exploration revealed extreme atony. A cervical laceration and bilateral sulcus tears were repaired. Patient was in profound shock one hour after delivery. Six grams of fibrinogen, intravenous fluids, and six pints of blood were administered over the next three hours, with stabilizing of blood pressure at 130/90 ml. mm Hg. Urinary output was noted to be only 115 mg/100 ml during these first three hours of emergency treatment. Urine output continued poor and on the fourth postpartum day, BUN had risen to 73 mg/100 ml, and peritoneal dialysis was initiated. The patient also became septic, and antibiotic therapy was instituted. By the tenth postpartum day, BUN had risen to 121 mg/100 ml, and some "coffee-ground" emesis was noted. At two weeks post-partum, the patient vomited, became cyanotic, and cardiac arrest followed. She was defibrillated and received hypo-

thermia for her comatose state. Some diuresis, up to 4000 cc per day, ensued but the patient did not regain consciousness and died.

Cause of Death (Autopsy): The pathologic findings were bronchopneumonia, pulmonary edema, acute gastric ulcers, acute renal tubular degeneration, and endometritis. Azotemia and afibrinogenemia were listed as clinical conditions.

Comment of Consultant

The following comment of a consultant specializing in obstetrics and gynecology was given at the request of The Committee:

"In the present day, when blood banks have been established in metropolitan areas, it would seem that the availability of this potential life-saving agent would reduce the number of deaths due to exsanguination, or 'oligemia' resulting in acute renal tubular necrosis.

"However, these three cases represent two salient sagas, ie, 'too little, too late' and 'inadequate prenatal care.' The early recognition of the potential end result of severe hemorrhage in obstetrics, of course, is the key

solution of the problem.

"On the other hand, the skill of the obstetrician will overshadow the duress of an 'hemorrhagic emergency.' The risk of circulatory overload, and possible allergic reactions are hazards to be evaluated quickly by the obstetrician and his staff. Frequently, factors involving anesthesia, and other conditions, also must be considered when auxiliary measures are instituted at the time of the

"Obviously, as in all catastrophies related to obstet-

rics, 'prevention is paramount.'"

The Consulting Medical Editor takes the privilege of commenting on the treatment of the 21-year-old mother who died two weeks following the stillborn delivery of her third pregnancy. The following is noted: "A uterine pack was inserted with no cessation of bleeding." For many years, the fallacy of introducing a uterine pack into the uterine cavity has been stressed by national leaders in the field of obstetrics and gynecology. Determination of the cause of the bleeding and the correction of it is the keynote of treatment. A uterine pack hides both the cause and the resulting hemorrhage and may, if left in situ more than a very limited period of time, provide the site of an endometrial infection which will further complicate the cause of bleeding and resultant hemorrhagic condition.—R.L.M.

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INDICATIONS: Therapeutically (as an adjunct to systemic therapy when indicated) for topical infections, primary or secondary, due to susceptible organisms, as in:
- infected burns, skin grafts, surgical incisions, otitis externa - primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) - secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) - traumatic lesions, inflamed or suppurating as a result of bacterial infection.

<u>Prophylactically</u>, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing. **CONTRAINDICATIONS**: Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components. **WARNING**: Because of the potential hazard of nephrotoxicity and ototoxicity due to



neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended. PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



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Joint Underwriting Assn. Update

Since the inception of the Joint Underwriting Association (JUA), several questions have arisen concerning the coverage. The JUA, which is officially known as the Ohio Medical Professional Liability Underwriting Association, has provided some of the more frequent queries with appropriate answers.

The JUA policy will cover the physician if he periodically provides medical care outside the State of Ohio. However, he should notify the JUA if he plans to practice in a state other than Ohio for more than six months of

the year.

The Stabilization Reserve Fund (SRF) is to be collected annually, either through the private market or through the JUA policies that it issues, until the fund reaches \$40,000,000. When the fund reaches the limit, the Director of Insurance has the authority to waive future SRF charges.

The monies collected by the Stabilization Reserve Fund are to be kept until the JUA ceases doing business and all outstanding losses and expenses have been satisfied. At that time, the monies will be distributed to those paying into the SRF in the same proportion as they con-

tributed to the fund.

If a physician cancels his JUA policy, the SRF charge is not returnable. Once the SRF charge has been collected by the JUA, it is forwarded to the Stabilization Reserve Fund and will not be redistributed until the fund is discharged.

The claims-made contract has a rating structure that contemplates a delay in paying the total premium to assure occurrence coverage at the end of the last policy purchased from the claims-made insurer. The JUA will offer tail coverage to retiring physicians and estates and also to physicians able to purchase coverage in the voluntary market upon notice that the JUA coverage is no longer required.

The premiums for renewal coverage in the JUA will be higher than the first-year levels due to the claimsmade concept. However, those premium levels have not yet been finalized, but they will be in the near future.

Attorneys to Register With Ohio Supreme Court

Under a new rule which becomes effective January 1, 1976, all attorneys practicing in Ohio must register with the Ohio Supreme Court. The registration also involves the payment of a \$50 fee, collected every two years, which will finance an investigative staff. This staff will include among its duties investigating complaints,

searching out individuals in unauthorized practice, and making sure attorneys adhere to their code of professional conduct.

According to Joseph Miller, Executive Director of the Ohio State Bar Association, the new rule is the legal counterpart of the State Medical Board. The rule is designed such that attorneys not registering with the court will not be allowed to practice law in Ohio.

In addition to lawyers, other professionals must also register annually with their respective boards. Cost for renewal of licenses is fairly uniform among the professionals: audiologists, speech pathologists, chiropractors, and optometrists pay \$50. Dentists pay \$30; embalmers and funeral directors \$27; psychologists and veterinarians \$25. Physicians now pay \$5 annually. This fee will increase to \$50 triennially in 1980.

Narcotic License Renewals Slow

OSMA has received word that the Federal Drug Enforcement Administration (DEA) is running about six months behind in renewing narcotic registrations for physicians. The DEA is extending the old registrations. However, if a doctor receives nothing within a month after sending his re-registration form and check, he should contact the DEA regional office in Detroit. The direct number to the registration office is 313-226-6725. A woman named Rose is the main contact.

Thermography Use Defined In Breast Cancer Detection

A new policy limiting the use of thermography in the detection of breast cancer has been established by the American College of Radiology and the American Thermographic Society. The new position recognizes thermography as a complementary diagnostic tool that may be useful in the evaluation of breast disease when combined with both physical examination under the supervision of a qualified physician and mammography by a trained radiologist.

The two medical groups stressed that thermography is not considered an adequate screening method for the detection of breast cancer or other breast disease when used alone or when combined only with physical examination.

Thermography is a non-invasive technique that records areas of increased heat in the breast. Physicians believe that elevated temperatures in the breast suggest the presence of cancer because cancer cells grow more rapidly than normal cells and thus produce more heat.

(continued on page 850)

CONTINUED (continued from page 849)

Canton Physician Edits Ophthalmology Text

Little, Brown and Company has released The Ophthalmologist's Office: Planning and Practice co-edited by Frank J. Weinstock, M.D., of Canton, and Herve M. Byron, M.D. The editors, who believe that sound business management results in the best patient care, have designed a text to help any ophthalmologist build personal and professional satisfaction in his practice.

The editors and six authors discuss selecting, designing, equipping, staffing and organizing the office. In addition, financial and medical record-keeping techniques, aspects of insurance protection, investments, and the selection of legal assistance in conducting one's prac-

tice are highlights of the book.

Dr. Weinstock, a board-certified ophthalmologist and a Fellow of the American College of Surgeons, is Clinical Assistant Professor in Ophthalmology at The Ohio State Universty Department of Ophthalmology. He served as president of the Canton Academy of Medicine in 1973. Dr. Weinstock instructs a course on "Glaucoma Detection" annually at the meeting of the American Academy of Ophthalmologists and Otolaryngologists. He is also Chairman of the Medical Advisory Committee of the Ohio Society for the Prevention of Blindness and Vice-Chairman of the Child Health Committee of the American Association of Ophthalmology.

VA Physician Salaries Augmented

In October, the President signed new legislation that provides for increase in total pay of full-time Veterans Administration (VA) doctors. This increase amounts to \$7000 including the recent five percent general increase effected in October for all federal employees. The law also enables doctors to qualify for up to \$6,500 in additional "incentive special pay," depending on their seniority in the VA, their medical specialty, the extent to which they have continued professional education, and their administrative responsibilities.

Physicians working less than full time, but more than half time for the VA will be given similar increases proportionate to the extent of their time spent in VA employment. The law provides that doctors now employed or who are recruited may sign agreements to serve for up to four years under the salary augmentation. They must sign the agreement within the single year the legislation will remain in effect.

According to Dr. John D. Chase, Chief Medical Director of the VA, the new incentive pay law for doctors provides the Veterans Administration Department of Medicine and Surgery with an exceptional opportunity to recruit needed new professional staff members.

(continued on page 880)

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DESCRIPTION: Each 15 ml. (one tablespoonful) contains potassium chloride 1.5 Gms., supplying 20 mEq. of elemental potassium, and 20 mEq. of chloride, in a cherry-flavored, palatable base; alcohol 4%. Contains no sugar.

INDICATIONS: Treatment of potassium deficiency occurring especially during thiazide diuretic or corticosteroid therapy, digitalis intoxication, low dietary intake of potassium, or as a result of excessive vomiting and diarrhea. Other causes of hypokalemia are fistulae, laxative abuse, villous adenoma, familial periodic paralysis, hyperthyroid periodic paralysis, insulinoma, primary aldosteronism or secondary aldosteronism, Cushing's Disease, renal potassium wasting conditions such as potassium wasting nephritis, and alkalosis.

CONTRAINDICATIONS: Impaired renal function, untreated Addison's Disease, dehydration, heat cramps and hyperkalemia.

PRECAUTIONS: Potassium chloride should be administered with caution and adjusted to the requirements of the individual patient, since the amount of deficiency and corresponding daily dose is often not known. Excessive or even therapeutic doses may result in potassium intoxication. The patient should be checked frequently and periodic ECG and/or plasma potassium levels made. High plasma concentrations of potassium ion may cause cardiac depression, arrhythmias or arrest. Use with caution in patients with cardiac disease. In hypokalemic states, attention should be directed toward the correction of the frequently associated hypochloremic alkalosis.

ADVERSE REACTIONS: Vomiting, nausea, abdominal discomfort and diarrhea may occur. Symptoms and signs of potassium intoxication include listlessness, mental confusion, paresthesia of the extremities, weakness of the legs, flaccid paralysis, fall in blood pressure, cardiac arrhythmias, and heart block. When hyperkalemia exists, it should be promptly treated with the discontinuance of potassium administration or other steps to lower serum levels if indicated, since sudden shift in plasma levels may induce potentially dangerous cardiac arrhythmias.

DOSAGE AND ADMINISTRATION: One tablespoonful of 15 ml. (equal to 20 milli-equivalents) diluted in a 4 ounce glass of water, tomato or orange juice twice daily after meals will be sufficient to replete potassium losses in most hypokalemia patients. Some patients (approximately 30 percent), will require a dose of 15 ml. t.i.d. to reverse diuretic-induced hypokalemia patients. However, these patients require close supervision to avoid the possibility of potassium intoxication. Patients should be cautioned to follow directions implicitly in regard to dilution of Kay Ciel Elixir to prevent gastrointestinal injury.

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"Potassium chloride is preferred to other salts of potassium since, in most hypokalemic states, hypochlore. mia is also present and chloride ion is needed to allow complete potassium replacement."1

"In general, the chloride salt is preferable because of the participation of chloride in the renal conservation of potassium."

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"If potassium depletion is accompanied by a deficit of chloride, it may be quite difficult to correct that deficit and dissipate the alkalosis unless adequate quantities of chloride are made available."3

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(potassium chloride) 10%

Replaces more than just potassium

1. AMA Drug Evaluations, ed. 2. Publishing Sciences Group, Inc., Acton, Mass., 1973, p. 184

2. Sandstead, H., in Wintrobe, M.M. et al. (Eds.): Harrison's Principles of Internal Medicine, ed. 7, New York, McGraw-Hill Book Company, 1974, p. 441 3. Welt, L.G., in Goodman, L.S., and Gilman, A. (Eds.) The Pharmacological Basis of Therapeutics, ed. 4. New York, The Macmillan Company, 1970, pp. 798-799

Report on Implementation of Amended Resolution 7-75

The House of Delegates of the Ohio State Medical Association passed at its 1975 meeting, Substitute Resolution No. 7-75. ("Employ Non-Staff Physicians to do PSRO, Utilization Review, Certification and Review.")

This resolution resolved "that the Council of the Ohio State Medical Association inform the membership of the Ohio State Medical Association of all options available to them under Public Law 89-97" and further "that option three of Section (K)(2)(B) of Public Law 89-97 is available, which would allow non-staff physicians to do utilization, certification and review."

Public Law 89-97 provided for the creation of the Medicare program. One of the conditions for participation of a hospital in the Medicare program is that it "has in effect a hospital utilization review plan which meets the requirements of subsection 1861 (K) entitled 'Utilization Review'."

This subsection is reproduced as follows:

"Utilization Review

"(k) A utilization review plan of a hospital or extended care facility shall be considered sufficient if it is applicable to services furnished by the institution to individuals entitled to insurance benefits under this title and if it provides—

"(1) for the review, on a sample or other basis, of admissions to the institution, the duration of stays therein, and the professional services (including drugs and biologicals) furnished, (A) with respect to the medical necessity of the services, and (B) for the purpose of promoting the most efficient use of available health facilities and services;

"(2) for such review to be made by either (A) a staff committee of the institution composed of two or more physicians, with or without participation of other professional personnel, or (B) a group outside the institution which is similarly composed and (i) which is established by the local medical society and some or all of the hospitals and extended care facilities in the locality, or (ii) if (and for as long as) there has not been established such a group which serves such institution, which is established in such other manner as may be approved by the Secretary;

"(3) for such review, in each case of inpatient hospital services or extended care services furnished to such an individual during a continuous period of extended duration, as of such days of such period (which may differ for different classes of cases) as may be specified in regulations, with such review to be made as promptly as possible, after each day so specified, and in no event later than one week following such day; and

"(4) for prompt notification to the institution, the

individual, and his attending physician of any finding (made after opportunity for consultation to such attending physician) by the physician members of such committee or group that any further stay in the institution is not medically necessary.

The review committee must be composed as provided in clause (B) of paragraph (2) rather than as provided in clause (A) of such paragraph in the case of any hospital or extended care facility where, because of the small size of the institution, or (in the case of an extended care facility) because of lack of an organized medical staff, or for such other reason or reasons as may be included in regulations, it is impracticable for the institution to have a properly functioning staff committee for the purposes of this subsection."

Section 1861 (k)(2) provides for three methods by which utilization review may be conducted. These are as follows:

(1) by a staff committee of the institution composed of two or more physicians; or

(2) by a group outside the institution which is similarly composed and which is established by the local medical society and some or all of the hospitals and skilled nursing facilities in the locality; or

(3) by a group outside the institution which is similarly composed, if (and for as long as) there has not been established such a group which serves the institution, which is established in such other manner as may be approved by the Secretary.

The Secretary of the Department of Health, Education and Welfare has the responsibility of determining whether or not a hospital's utilization review complies with conditions for participation. The Secretary has delegated this responsibility to the Bureau of Health Insurance in the Social Security Administration.

The Bureau of Health Insurance has repeatedly stated its policy that the utilization review function be carried out by a staff committee of the hospital and that alternative methods will be considered only if the size of the hospital's medical staff is such that the medical staff does not have the capacity to perform utilization review.

The last paragraph of Section 1861 (k) requires that a group outside the institution must be used in the case of any hospital or extended care facility where, (1) because of the small size of the institution, or (2) (in the case of an extended care facility) because of lack of an organized medical staff, or (3) for such other reason or reasons as may be included in regulations, it is impracticable for the institution to have a properly (continued on page 863)

obituaries

Richard P. Bell, M.D., Cleveland; Medico-Chirurgical College of Philadelphia, 1912; age 88; died October 24; member of OSMA and AMA.

Leonard Biskind, M.D., Cleveland; Case Western Reserve University, 1924; age 76; died September 22; member of OSMA and AMA.

George S. Bova, M.D., Toledo; St. Louis University School of Medicine, 1943; age 57; died October 18; member of OSMA and AMA.

Andrius Bridzius, M.D., Cleveland; Friedrich-Wilhelms University Berlin Prussia, Germany, 1926; died in August.

Daniel J. Brody, M.D., Memphis, Tennessee; died October 2.

Joseph Collins, M.D., Cincinnati; age 67; died October 4.

Philip Cloverdale, Jr., M.D., Heath; Medical College of Wisconsin, Milwaukee, 1962; age 43; died October 10; member of OSMA and AMA.

Nicholas S. D'Alessandro, M.D., Cleveland; St. Louis University School of Medicine, 1928; age 75; died October 11; member of OSMA.

Dewitt Harrison, M.D., Polson, Montana; University of Rochester School of Medicine and Dentistry, 1943; age 58; died September 28; member of OSMA.

William Kaumeyer, M.D., Columbus; Ohio State University College of Medicine, 1946; died October 6; member of OSMA and AMA.

Hilary Layzer, M.D., Cleveland; University of Strasbourg, France, 1922; age 87; died October 14.

Ping Chung Ling, M.D., Xenia; National Shantung University Medical College, Tsingao, Shantung, 1941; age 59; died October 20; member of OSMA and AMA.

A. Ward McCally, M.D., Dayton; Columbia University College of Physicians and Surgeons, New York, 1945; age 54; died October 22; member of OSMA and AMA.

Michael Orlando, M.D., Redlands, California; Northwestern University Medical School, Chicago, 1956; age 43; died September 25; member of OSMA and AMA.

John Wm. Robinson, M.D., Salt Lake City, Utah; University of Cincinnati College of Medicine, 1968; age 36; died October 16; member of OSMA and AMA.

Joseph M. Rossen, M.D., Cleveland; University of Michigan Medical School, 1927; age 74: died October 14; member of OSMA and AMA.

Russell Rummell, M.D., Youngstown; Jefferson Medical College, Thomas Jefferson University, Philadelphia, 1929; age 75; died October 7; member of OSMA and AMA.

Henry Snow, M.D., Boca Raton, Florida; Ohio State University College of Homeopathic Medicine, 1915; age 83; died October 24; member of OSMA and AMA.

Bliss M. Wiant, M.D., Delaware; died October 16.

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New Malpractice Law Requires Proof of Continuing Education

Ohio's new medical malpractice law requires every physician to actively pursue Continuing Medical Education (CME). Physicians must be able to certify that they have completed at least 150 hours of CME in order to be re-registered by the State Medical Board. The OSMA staff has received many questions from members concerning the new requirement, especially when it will start and how it will operate.

The Section of the law on CME reads in part:

"Every doctor of medicine licensed to practice medicine or surgery within this State shall, on or before the first day of January of every third year after the 1977 registration, apply to the State Medical Board for a certification of triennial registration with the Board upon an application which shall be furnished by the Board, and shall pay at such time a fee of fifty (\$50) dollars to the Board.

". . . The applicant shall include satisfactory evidence to the Board that in the preceding three years the practitioner had completed one hundred fifty (150) hours of continuing medical education certified by the Ohio State Medical Association and approved by the Board."

Under this law, the Ohio State Medical Board will begin triennial re-registration of physicians (instead of the current biennial) in 1980. At that time, all physicians wishing to be re-registered must certify completion of at least 150 hours of CME between January 1, 1977, and December 31, 1979. Any CME credits received in 1975 or 1976 will not be included in the first triennial registration in 1980. Only CME credits accumulated after 1977 will apply.

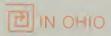
At present, the OSMA is working with the State Medical Board to establish a plan for the implementation of the CME requirement. As many physicians know, the OSMA has a 1975 Physician's Recognition Program with 11 categories. Because of the confusion between the OSMA's Physician's Recognition Program and the AMA's Physician's Recognition Award (which has only six categories), the OSMA is considering establishing a CME program that would run parallel to the AMA's.

By making the OSMA program similar to the AMA's, any physician who meets the CME criteria of OSMA would automatically meet the criteria of the AMA Physician's Recognition Award. Thus, specialty societies and medical organizations which have worked out mutual programs of recognition with the AMA would be automatically recognized by the OSMA.

By February 1976, with the approval of the State Medical Board, the OSMA hopes to be able to publish, in The Journal, the criteria and mechanisms for the 1977-1979 CME requirement for the first triennial registration in 1980.

If you have any further questions, please direct them to the OSMA Commission on Medical Education.

CONTINUING



Ohio Medical Education Network Programs (see the October 1975 issue of *The Journal*, page 733, for explanation):
Clinical Pathological Conference (Adult), Dec. 15-19, 1975
Value of Staging and Therapy in Management of Lymphomas, Jan. 5-9, 1976

Recurrent Lower Urinary Tract Symptoms, Jan. 12-16 Selection of Antibiotics, Jan. 19-23

Amniocentesis, Jan. 26-30

Chemotherapy — Annual Report, Feb. 2-6 Management of Acid Peptic Disease, Feb. 9-13

Clinical Pathological Conference (Pediatric), Feb. 16-20 Management of Thyroid Nodules, Feb. 23-27

Current Blood Bank Problems; Jan. 7-8; Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; \$80 registration fee; acceptable for Category 1 credit toward AMA Physician's Recognition Award.

Family Medicine Review; Jan. 10-11 and/or 24-25; Imperial House N., Interstate 71 and Morse Rd., Columbus; sponsored by the Ohio Academy of Family Physicians, 4075 N. High St., Columbus 43214; registration fee \$25 resident, \$75 member, \$125 non-member (per weekend).

Medical Problems Encountered In Sex Counseling Clinic; Jan. 13; sponsored by the Fort Steuben Academy of Medicine, 525 N. 4th Street, Steubenville.

Surgical Technics, "How I Do It"; Jan. 14-15; Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; acceptable for Category 1 credit toward the AMA Physician's Recognition Award.

Core Curriculum: Pediatric Echocardiography; Jan. 19-22; Children's Hospital, Cincinnati; sponsored by the American College of Cardiology, 9650 Rockville Pike, Bethesda, Md. 20014; registration fee \$150 member American College of Cardiology, \$200 non-member.

Cytogenetic Endocrinology Teratology; Jan. 21, Marriott Inn, Cleveland; sponsored by the Cleveland Society of Obstetricians and Gynecologists, 1445 Blackmore Rd., Cleveland Heights 44118.

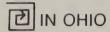
Gastroenterology Seminar; Jan. 28; Fawcett Center for Tomorrow, 2400 Olentangy River Rd., Columbus; sponsored by the Ohio State Center for Continuing Medical Education, 320 W. 10th Ave., Columbus 43210; \$40 registration fee.

Medical Progress for the Family Physician; Jan. 28-29; co-sponsored by the Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106, and the Cleveland Academy of Family Practice; \$60 registration fee; acceptable for Category 1 credit toward AMA Physician's Recognition Award.

Core Content Review; Jan.-June (home study); sponsored by the Ohio Academy of Family Physicians, 4075 N. High St., Columbus 43214; registration fee \$40 member, \$60 non-member.

Electromyography Seminar; Feb. (4 days); Dodd Hall, Columbus; sponsored by Ohio State Univ. Center for Continuing Medical Education, A352 Starling Loving, 320 W. 10th Ave., Columbus, 43210; registration fee \$225.

(continued on page 858)



(continued from page 857)

Infectious Diseases; 8th annual conference; Feb. (1 day); Univ. of Cincinnati Medical Center; sponsored by Univ. of Cincinnati College of Medicine, Office of CONMED, Dean's Office, Suite E251, 231 Bethesda Ave., Cincinnati 45267.

OB/GYN; Feb. (1 day); Univ. Cincinnati Medical Center; sponsored by Univ. of Cincinnati College of Medicine, Office of CONMED, Dean's Office, Suite E251, 231 Bethesda Ave., Cincinnati 45267.

Urologic Outing; Feb.; sponsored by Ohio State Univ. Center for Continuing Medical Education, A352 Starling Loving, 320 W. 10th Ave., Columbus 43210; registration fee \$75.

Infectious Disease Seminar; Feb. 4; Fawcett Center for Tomorrow, Columbus; sponsored by Ohio State Univ. Center for Continuing Medical Education, A 352 Starling Loving, 320 W. 10th Ave., Columbus 43210; registration fee \$40.

Renal Disease Seminar; Feb. 4; Univ. of Cincinnati Medical Center; sponsored by Univ. of Cincinnati College of Medicine, Office of CONMED, Dean's Office, Suite E251, 231 Bethesda Ave., Cincinnati 45267.

Computed Tomography of the Head and Body; Feb. 4-5, Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 4+106; registration fee \$100; acceptable for 13 hours Category 1 credit toward AMA Physician's Recognition Award.

The Environment, The Operation, The Anesthetic; Feb. 7-8; Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; registration fee \$100; acceptable for Category 1 credit toward AMA Physician's Recognition Award.

Management of Arthritis; Feb. 10; sponsored by Fort Steuben Academy of Medicine, 525 N. 4th St., Steubenville.

Endocrine Disorders, Diabetes and Hypoglycemia; Feb. 11-12; Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; registration fee \$80; acceptable for Category 1 credit toward AMA Physician's Recognition Award.

Pediatric Workshop; Feb. 13-15; Hueston Woods Lodge, College Corner; sponsored by Ohio Academy of Family Physicians, 4075 N. High St., Columbus 43214, co-sponsored by Indiana Academy of Family Practice; registration fee \$45 members, \$55 non-members, \$25 residents.

Ear, Nose, Throat Disorders; Feb. 18; Stouffer's Univ. Inn, Columbus; sponsored by Ohio State Univ. Center for Continuing Medical Education, A352 Starling Loving, 320 W. 10th Ave., Columbus 43210; registration fee \$40.

New Morality — Neither New Nor Moral; Feb. 18; Cleveland Health Museum; sponsored by the Cleveland Society of Obstetricians and Gynecologists, 1445 Blackmore Rd., Cleveland Heights 44118.

Hypertension and Renal Disease; Feb. 18-19; Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; registration fee \$80; acceptable for Category 1 credit toward AMA Physician's Recognition Award.

IMPORTANT INFORMATION: This is a Schedule V substance by Federal law; diphenoxylate HCI is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCI) or Narcan® (naloxone HCI) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCi or atropine.

sensitive to diphenoxylate HCi or atropine.

Warnings: Use with special caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCi may potentiate the action of barbiturates, tranquilizers and aicohol. in theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis. In severe dehydration or electrolyte imbalance, withhold Lomotii until corrective therapy has been initiated.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCI and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxyiate HCI is theoretically possible at high dosage. Do
not exceed recommended dosages. Administer with
caution to patients receiving addicting drugs or
known to be addiction prone or having a history of
drug abuse. The subtherapeutic amount of atropine
is added to discourage deliberate overdosage;
strictly observe contraindications, warnings and precautions for atropine; use with caution in children
since signs of atropinism may occur even with the
recommended dosage. Use with care in patients with
acute ulcerative colitis and discontinue use if abdominal distention or other symptoms develop.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing, hyperthermia, tachycardia and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria, paralytic lieus, and toxic megacoion.

Caria, paralytic fields, and toxic megacolon.

Dosage and administration: Lomotil is contraindicated in children less than 2 years old. Use only Lomotil iliquid for children 2 to 12 years old. For ages 2 to 5 years, 4 mil. (2 mg.) q.i.d.; 8 to 12 years, 4 mil. (2 mg.) 5 times daily; adults, two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 mil., 5 mg.) q.i.d. or two regular teaspoonfuls (10 mil., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, hyperthermia, tachycardia, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. A narcotic antagonist may be used in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg, of diphenoxylate HCI with 0.025 mg, of atropine suifate, Liquid, 2.5 mg, of diphenoxylate HCI and 0.025 mg, of atropine suifate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz, bottle of Lomotti liquid.

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Following are names of new members of the Ohio State Medical Association certified to the headquarters office during October, 1975. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

Belmont (Bellaire) Adiel C. Anghie Kasib L. Aziz Alaud Din Clark (Springfield) Amrit L. Chadha Zailful A. Girgus John Z. Little Kumar Mukerjee Cuyahoga (Cleveland) James D. Brodell Robert L. Druet Roger H. Hertz Saghir U. R. Mir Malvika S. Shah Inia E. Veloso Carlos E. Zevallos Hamilton (Cincinnati) Dennis A. Blanchard Barry A. Blum Bernard B. Foster, Jr. Paul M. Gillingham Stacey Greenert James M. Hall Warren G. Harding, III Kenneth B. Hyams Jerome J. Kleinman Walter E. Matern Roger V. Meyer Paul R. Schwetschenau Bhanukumar C. Shah Lee J. Shonfield Robert J. Smyth Richard A. Tibbals

Grant K. Varion Lucas (Toledo) Peter M. Royen Montgomery (Dayton) Dechamma Alexander Dennis Barek John D. Bullock Robert N. Downer James P. Graham Tae W. Kim Etta C. Leahy Sidney F. Miller Richard B. Reiling Raymond G. Russell Iames A. Sims Richard R. Six John T. Thiel Nikou Yazdanbakhsh Portage (Ravenna) Robert W. Egdell Sandusky (Fremont) Dale A. Solze Stark (Canton, except where noted) Richard W. Belcher James D. Burkholder Sajid -U-Q- Chughtai Dante R. Geronille Dhia Hassani (Massillon) Ricardo Limardo-Arzeno Bruce R. Weiner James S. Young, Jr.

Logan (Bellefontaine)

Resolution 7-75 (continued from page 852)

functioning staff committee for the purposes of conducting utilization review.

The question arises as to whether it is "impracticable" for the institution to have a properly functioning staff committee if the medical staff feels that utilization review is not its responsibility. The Bureau of Health Insurance maintains that if a hospital medical staff has the capacity to effectively perform utilization review, other alternatives will not be considered.

The OSMA is currently seeking reinterpretation of this restrictive policy in order that hospitals may use the third option if the medical staff so decides.

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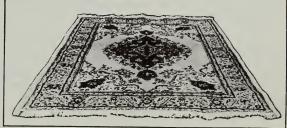
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Ohio Health News.

Course Offered for Hospital Infection Control Personnel

The Communicable Diseases Division of the Ohio Department of Health will be conducting week-long training courses for hospital infection control personnel in Akron, Bowling Green, Athens, and Dayton during the month of January. The courses are designed for full or part-time infection control personnel who have not attended the Hospital Infections Course at the Center for Disease Control in Atlanta. A recent survey of hospitals revealed that less than 30 percent of the currently employed infection control personnel have any background or training for their positions.

It is the goal of the Department of Health that every hospital in Ohio have trained infection control personnel to coordinate and implement a total infection control program as recommended by the American Hospital Association and the Joint Commission on the Accreditation of Hospitals.

Department of Health Stand On Heimlich Maneuver Supported

Editorials in major Ohio newspapers have supported the Department of Health's endorsement of the Heimlich method of preventing death by choking. Thousands of individuals and organizations have written for the department's brochure about the Heimlich maneuver, and some people have sent testimonials about how lives have been saved through the use of this procedure. Since the department's campaign began, the American Medical Association has endorsed the Heimlich maneuver.

Plasmapheresis Center Law Goes into Effect

On September 19, 1975, the Ohio Department of Health became responsible for regulating plasma centers other than those located in hospitals. Application forms for licensure of the centers and for approval of attending medical personnel have been sent to the 21 centers currently operating in Ohio. After receipt of an application,

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SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid.
As a secondary reaction some will complain of nausea, sweating and abdominal cramps. The reaction is usually transient.
INDICATIONS: As a cerebral stimulant and vasodilator.
RECOMMENDED GERIATIC DOSAGE: One capsule three times daily adjusted to the individual patient.
WARNING: Overdosage may cause muscle tremor and convulsions.

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Write for literature and samples . . .

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the Communicable Diseases Division staff will inspect the center for compliance with departmental regulations. In addition, the department may periodically request that samples of collected materials be submitted to be analyzed

for sterility and the presence of disease.

One of the primary goals of this legislation is the protection of plasma donors against serum hepatitis. Each center will be required to report monthly to the local health commissioner the number of plasma donations, the number of hepatitis B antigen positive donations, and the names of all hepatitis B antigen donors. The centers must also report the names of all personnel and donors who develop hepatitis or other diseases, who have serious reactions related to plasmapheresis, and who test positive for syphilis.

Immunization Districts

The map shows the new boundaries of the Ohio Department of Health immunization districts. Also listed are the public health representatives assigned to the districts. When in need of immunization information, physicians should contact their local health department.

New Hearing Aid Report

On September 29th, the U.S. Department of Health, Education, and Welfare (HEW) released the final report

on hearing aid health prepared by an HEW intradepartmental task force. Here are some of the recomendations:

- (1) A person buying a hearing aid for the first time should be examined by a physician and receive medical
- (2) A label should state that a hearing aid will not restore normal hearing or prevent or improve organic conditions causing hearing impairment.
- (3) A national education program should be developed on hearing health care, and the HEW agencies should sponsor continuing education and training programs for health professionals.
- (4) HEW should consider including the cost of hearing aids and hearing care in programs such as Medicare.
- (5) HEW should develop programs to provide hearing health services to neglected population groups.

Many recommendations will be addressed in hearing aid labeling regulations expected to be published soon by the Food and Drug Administration (FDA). These regulations will propose that:

(1) A medical clearance be required within six months prior to the sale of all hearing aids to assure that medically treatable conditions which may affect hearing are identified and treated before an aid is purchased.

(continued on page 866)



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Thiamine HCL (B-1) 25 mg.	Th
Riboflavin (B-2) 2 mg.	Ri
Pyridoxine HCL (B-6) 10 mg.	P
DOSE: 1 to 5 tablets daily.	D
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1000	1/

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DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500
AVAILABLE: Dotties of 100, 500

GRADUAL RELEASE

LIPO-NICIN/300 mg. Each timed-release cap tains:	sule con-
Nicotinic Acid	.300 mg.
Ascorbic Acid	.150 mg.
Thiamine HCL (B-1)	. 25 mg.
Riboflavin (B-2)	
Pyridoxine HCL (B-6)	
DOSE: 1 to 3 tablets da	
AVAILABLE: Bottles of	100, 500,
1000	

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizzness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concinitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient. Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, Itching and tingling, skin rash, allergies and gastric disturbance may occur. ContraIndications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

WRITE FOR LITERATURE AND SAMPLES

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Ohio Health News (continued from page 865)

Consumers over 18 years old may waive medical clearance if none of seven specified warning signals are evident. These signals includes symptoms such as acute dizziness and a foreign body in the ear.

- (2) A brochure will be required to provide the consumer with general instructions on the use of the hearing aid.
- (3) Labeling must state, as recommended by the task force, that a hearing aid will not restore normal

hearing or improve organic conditions causing hearing impairments.

National Education Week on Smoking

The Chronic Diseases Division of the Ohio Department of Health is actively supporting a National Education Week on Smoking, January 11-17, sponsored by the National Interagency on Smoking and Health. The goal of the program is to discourage youth from starting to smoke or to encourage them to quit.



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John Kelly Cleveland, Ohio 44114 District No. 2

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Dayton, Ohio 45402

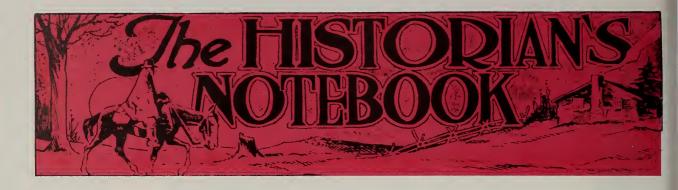
District No. 5 Shirley Kramer, R.N.* Cincinnati, Ohio 45219

District No. 6 Jack McSorley

Columbus, Ohio 43212

NOTICE TO ALL MEMBERS

- Your Membership in the Ohio State Medical Association and American Medical Association, including subscriptions to The Ohio State Medical Journal and The Journal of the AMA will expire on December 31. Here's how to renew
- Mail your dues immediately to the Secretary-Treasurer of Your County Medi-CAL SOCIETY or to the OSMA if your County Society has asked OSMA to direct bill for all three levels of dues on behalf of the Society.
- OSMA dues are \$125.00. AMA membership dues are \$250.00. Check with your local Secretary-Treasurer to determine the amount of your County Society dues. Ohio Medical Political Action Committee-American Medical Political Action Committee dues are \$35. OMPAC-AMPAC membershp is recommended.
- Life Active membership—a category of membership approved by the 1973 House of Delegates. This membership is available to 500 physicians who make a single, lifetime dues payment of \$1,250.00. When this payment is made, the life active physician is assured a full, active lifetime OSMA membership, subject only to maintenance of Ohio license and adherence to the Principles of Medical Ethics.
- Many members probably will want to send one check to cover local, state, national, and OMPAC-AMPAC dues. Your local Secretary-Treasurer will forward your state and national dues to the OSMA Columbus Office. That office will certify AMA dues. OMPAC-AMPAC dues will be forwarded to OMPAC Headquarters.
- As part of the privileges and services offered to all members of the OSMA, you will receive a year's subscription to The Ohio State Medical Journal and copies of the OSMAgram, without extra cost. Dues-paying members of the AMA will receive a year's subscription to The Journal of the AMA and the American Medical News.
- The member who becomes eligible for exemption from dues, and wishes to take advantage of exemption, should notify the secretary-treasurer of his County Medical Society. After exemption has been established, it is automatically renewed annually, unless the status changes.



History of a Successful Case of Cesarean Operation

John L. Richmond, M.D. Newtown, Ohio

In 1936, The Ohio State Medical Journal initiated a feature known as "The Historian's Notebook." This section incorporated a variety of articles dealing with medicine as it developed in the United States and, more especially, Ohio. "The Historian's Notebook" ran monthly under the head that appears here. It has only been in the recent past that the section began to appear sporadically. This month's bicentennial article is an excerpt from "The Historian's Notebook." This particular case history appeared in The Journal in April of 1937. The accompanying illustrations were not with the original article.

ON THE 22d of April, 1827, I was called to visit a Miss E. C. in labour; on my arrival at the house, I found she had been in labour about 30 hours. Two midwives had been called, but neither of them could give any account of the case, except that "she had fits and the pains did no good."

On examination, I found that the os externum, had suffered no dilation, and there was no foetal tumour in the pelvis, except when the pain was on, when there was a kind of pressing down of the uterus and the contents of the pelvis. The uterus presented a smooth tumour towards the superior extremity of the vagina, which seemed only to be felt through the anterior part of the vagina, and the anterior part appeared to form an acute angle with the posterior, immediately in the hollow of the sacrum, and a little posterior to the tumour.

She lay, by spells, comparatively easy; when her pains came on, they continued for a short space of time, nearly regular or natural, but in twenty or thirty seconds were transferred to the stomach, and immediately terminated in general convulsions, which continued from three to five minutes, and were succeeded by alarming faintings,

which lasted from ten to twenty minutes. The system was much exhausted, the pulse depressed, and not the least advantage yet resulted from all she had suffered.

My first object was, to prevent the convulsions and to recruit the system; for which purpose I gave laudanum and sulphuric ether, and applied flannel wet with hot spirits to the feet. These measures produced considerable mitigation of the convulsions, but the fainting increased. I had no recourse to cordials, for these could not be obtained. I was seven miles from home, and had but few medicines with me. I spent four hours in fruitless attempts, either to recruit my patient or to ascertain the exact condition of the mother, or the presentation of the child. The vagina seemed a kind of sack, the extremity of which could easily be reached with the finger, but nothing like a uterus, could be felt, except a tumour above, which was felt through the vagina; under these circumstances, finding my patient fast sinking, I requested advice, which, however, could not be obtained, on account of high water in the Little Miami and the darkness of the night.

I informed the patient and her friends, of the only means by which I could conceive of relief; this was at once consented to as affording some hopes of life.

After doing all in my power for her preservation, and feeling myself entirely in the dark as to her situation, and finding that whatever was done, must be done soon, and feeling a deep and solemn sense of my responsibility, with only a case of common pocket instruments, about one o'clock at night, I commenced the Caesarean Section. Here I must take the liberty to digress from my subject, and relate the condition of the house, which was made of logs that were green, and put together not more than a week before. The crevices were not chinked, there was

no chimney, nor chamber floor. The night was stormy and windy, insomuch, that the assistants had to hold blankets to keep the candles from being blown out. Under these circustances it is hard to conceive of the state of my feelings, when I was convinced that the patient must die, or the operation be performed.

I commenced the operation, by making an incision through the integuments, down to the linea alba from the umbilicus, to within an inch and a half of the pubis. I then made a short incision through the tendon, about one third of the way from the lower extremity of the other, and introducing my finger, I found that the omentum was much in the way, as she was very fat. I introduced the blade of a crooked pair of scissors, and crowding the omentum up with my finger, cut first up and then down. During this part of the operation, the haemorrhage was very trifling. I presume not exceeding four or five ounces.

As soon as the tension of the abdominal muscles was taken off, the convulsions subided, and the patient became composed and tranquil. The uterus then presenting, I proceeded to divide it in the same manner as I had done the linea alba. I made the incision from as low down as I could, to near the fundus uteri; the incision passed immediately over the placenta. This incision produced considerable haemorrhage, which however, soon partially subsided and I, then, divided the placenta, by making a small incision in it, and then lacerating it, which I thought would occasion less haemorrhage than to cut the whole of it. I then suffered all the blood to escape that I could, while the whole cavity of the abdomen was filled; and wiped away all I could, before trying to remove the child.

The child lay with the back presenting to the incision, the head resting on the superior strait of the pelvis; the uterus and placenta being thus divided, the contractions of the former were rapid, and the latter soon became



A Caesarean Operation in the 17th century. Courtesy Merck, Sharp and Dohme.

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And adopted Jusy 1855, by THE PHYSICIANS OF MEDINA COUNTY
For Office prescription, 25c to 81 B: ducing dislocated elbow 5 to 15 50cts " wrist 5
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"Consultation visit, from 1 to 3 do consultation visit, from 1 to 3
Mileage to be added. do Enlargeo 's'onsils do 10 " Prescription for Gonor- Operation for acresis and
rlue fee in advance from 5 to 20 exostosis 15 to 30 "Prescription for Syphilis Empertant operation on eye 25 to 59
fee in advance. 10to 50 Minor " " 5 to 20 Obstetrics. Reducing hermia and apply-
For Natural case of delivery \$4 to 5 mig truss 1 to 5 mig truss * Instrumental case * \$50.15 Dressing recent wounds, open-
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putations, lithotomy, her- nia, trephiaing, &c., \$30 to 100 or perinco 5 to 25
For adjusting fractured Passing catheter or bongie 1 to 5 femus. 10 to 25 Paracentesis, thoracis, ab-
" " humerus 5 to 10 Operation for hydrocele, 5 to 50
6 " cither 5 cent w 25.34 % 15.30
Reducing dislocated shoulder 3 to 5 Operation on hare lip 10 to 20
B. 1. December 1. December 2. December 2. December 2. December 2. December 3.
Dr. H. Alden. Dr. C. N. Lyman. Dr. E. H. Sibley.
* L. D. Tolman, "H. Spillman. J. Howard. * N. Eastman, "A C. Smith, H. J. Grismer, "H. Tiffany, P. E. Munger, "W. II Painter,
"S. Hills, "H. Warner, "Wm P. England, "M. Houg, "J. C. Bradford, "J. H. Carpenter,
" J. C. Preston, " A. G. Willey, " T. Hunter. " S. Hudson, " E. G. Hard, " D. Palmer.
" E. R. McKenzie,

1855 Fee Bill adopted by physicians of Medina County. Note the obstetrical procedure charges. From the Collection of the Howard Dittrick Museum of Historical Medicine, Cleveland.

entirely detached. As soon as the gush of blood partially subsided, I commenced my efforts to remove the child; but as it was uncommonly large, and the mother very fat, and having no assistance, I found this part of my operation more difficult than I had anticipated. My first endeavor was to raise the child sufficiently towards the stomach, to bring the head from under the pubis; but this I was unable to do, by any force which appeared to me safe to exert. I then made several vain attempts to raise the breech. After which I endeavored to pass my hand around the child, and get hold of the feet, but this the patient could not endure; and thinking the danger of the mother very great; and believing or supposing, that the child was dead from the detachment of the placenta; and considering, at all events, that a childless mother, was better than a motherless child, I determined to do all I could for the preservation of the mother. Accordingly I made a transverse incision across the back of the foetus, near the upper lumbar vertebrae, and the muscles of the back being divided, it formed an angle instead of a curve, by which means I was enabled, easily to extract it. The

(continued on page 870)

Cesarean Operation (continued from page 869)

placenta, being entirely detached from the uterus, was at once removed, and the blood carefully wiped out of the uterus and all surrounding parts properly clean, I now determined to make, if possible, some discovery in relation to the orificium uteri. I accordingly passed my hand into the uterus; and, by examining carefully, I found an apperture which, to the touch, from within, did not seem to bear any resemblance to a natural orifice. I introduced the finger of the other hand, into the vagina and could not bring them into contact with each other-there seemed to be a kind of tube, leading from the uterus, to within about three-fourths of an inch of the meatus urinarius into which I could pass my finger at the upper extremity, to any distance, and not at all below. I then dressed the wound in the common manner, with sutures and adhesive straps, leaving about two inches of the lower extremity open.

She now lay perfectly easy and went to sleep. I kept her in one position for four days, keeping the bowels open with saline purges and injections. The lochial discharge commenced in about eight hours, and continued for five days; some discharge also occurred from the open part of the incision. That part of the wound which was closed, adhered by the first intention. I suffered her to take no nourishment but weak gruel. On the seventh day, I closed the lower part of the wound; but finding, on the twelfth, that an accumulation had taken place in the cavity of the abdomen, I opened a small orifice from which a large quantity of black very offensive blood and water, was discharged. I then introduced a female catheter, and with a pint syringe, threw in three pints of warm water with a small quantity of soap in it, and drew it back with the syringe, after the manner of a stomach pump; this I repeated six successive days, when the water which was injected ceased to be coloured and the orifice was suffered to close. The patient never complained of pain during the whole course of the cure. She commenced work in twenty-four days from the operation, and in the fifth week walked a mile and back the same day.

One circumstance I cannot forbear relating. As I was syringing out the abdomen, as above mentioned, a neighboring woman, standing by my side, said to her what makes you laugh? to which she replied, because it feels so queer. I looked at her face and she was laughing.

I have made a recent examination of this patient, pervaginam, and the condition of the vagina remains as above described, only it is now more shallow than it was when the uterus was raised into the abdomen; the whole depth of the vagina is now only two-thirds of a fingers length, the orifice, or abnormal os tincae, would not be discovered by the most minute examiner, who was not appraised of its situation. The anterior coat of the vagina now feels like a kind of septum, passing obliquely upward from before backward, leaving, I think, about one and a half inches between it and the forchet. I should think, if it were possible, that it is an unnaturally situated hymen. Here is as much room for others to theorize on the physiology of conception as for me. She has been married since and lived two years with a husband, during which time she tells me that she suffered great inconvenience on account of the shallowness of the vagina, but no conception has taken place. She suffers no inconvenience from the abdominal cicatrix, it being perfectly firm.-Newton, Hamilton County, Ohio, February, 1830. Western Journal of the Medical and Physical Sciences. Volume 3, page 485.

John L. Richmond, whose account of the first recorded Caesarean operation performed in this country is here reprinted, was a native of New York. He began the study of medicine in the office of a country practitioner but shortly thereafter his family migrated westward, first to Pittsburgh and later to Cincinnati. Richmond's formal education consisted of a few weeks at a country school in the State of New York. He matriculated in the Medical College of Ohio, earning his expenses by working as a janitor in the college building. After graduation he located in Newtown, Ohio, near Cincinnati. About 1832 he removed to Indiana, where he practiced medicine and preached as a minister of the Baptist Church. He subsequently formed a partnership in Indianapolis with Dr. Geo. Mears and his son, Corydon Richmond. Later he was compelled to retire on account of ill health, living with a daughter in Covington, Indiana. He was buried in Lafayette, Indiana. A monument erected in Newtown about 1912 commemorates this Caesarean operation.



THE OHIO STATE MEDICAL JOURNAL IS A BICENTENNIAL PARTICIPANT.

State Medical Board Issues Activity Report for 1974

The State Medical Board convened 24 times during 1974. Among matters considered by the board were approval of requests for endorsements, approval of examination grades, establishment of board policy, and consideration of findings made subsequent to informal or formal hearings being held.

In 1974, 613 examinations were administered to qualified applicants for certificates to practice medicine and surgery in Ohio. This marked a reduction from 1973 when 886 persons were examined.

The State Medical Board issued 373 certificates to physicians by examination; 833 certificates were issued by endorsement. These figures showed a decline from 1973's total of 712 certificates issued by examination, but a rise from 672 certificates issued by endorsement.

The FLEX examination was failed by 229 physicians in 1974, a decline from 313 in 1973. The board refused an endorsement license to 26 physicians in 1974 as opposed to six in 1973.

The biennial registration of doctors totaled 20,737 for 1973-1974. This figure marked a small increase over the previous figure of 20,583.

In 1974, the State Medical Board, through its investigators, conducted 334 investigations of illegal practice in 80 counties of the state. The board has the power to revoke and suspend certificates of licenses.

Following an investigation of an alleged violation of the Medical Practice Act, the board may utilize several alternative procedures. First, the board may summon the alleged offender to an informal office conference. Second, a citation letter may be drafted giving formal notice of the alleged violation. In this case, the licensee is given 30 days to request a formal hearing. After the hearing and its decision, the offender can appeal an adverse decision to the Court of Common Pleas, the Court of Appeals, the Supreme Court of Ohio, and the Supreme Court of the United States.

Third, the board may initiate criminal charges against alleged offenders. Fourth, the board can apply for injunctive proceedings against unlicensed practitioners of medicine subsequent to notifying the offender of alleged unlicensed practice. Fifth, the board may suspend certificates of mentally ill or incompetent practitioners after appropriate proceedings in the Probate Court.

Enforcement action taken by the board may culminate in revocation, indefinite suspension, definite suspension or voluntary surrender of the license. The most common infractions include the unlicensed practice of medicine or a limited branch of medicine, practice outside the scope of a physician's certificate, and the illegal prescribing of controlled substances.

In 1974, there were 87 cases warranting investigation as compared to 140 in 1973. No basis for further action was found in 50 cases in 1974 and 93 cases in 1973. In 1974, 13 people voluntarily surrendered their certificates; five surrendered their DEA (BNDD) certificates. Twenty cases were filed in 1974 with nine resulting in conviction. four in dismissal, and seven pending.

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1976 Annual Meeting, Ohio State Medical Association

DO YOU HAVE AN EXHIBIT or know of an exhibit which is of scientific interest? If you do, the Ohio State Medical Association Annual Meeting is just the place to display it. We are now accepting applications for the 1976 OSMA Annual Meeting. Those eligible to apply are as follows: (1) Exhibits by Ohio physicians, Ohio medical schools, hospitals or similar organizations; (2) Out-of-state physicians or out-of-state agencies on invitation; (3) Voluntary health organizations.

Exhibits will be set up and viewed at the Cincinnati Convention & Exposition Center, 200 West Fifth Street, Cincinnati, Ohio. Exhibit Days and Times will be as follows: Monday, May 10-12:00 Noon - 4:30 P.M.; Tuesday, May 11-9:00 A.M. - 4:30 P.M.; and Wednesday, May 12-9:00 A.M. - 3:00 P.M.

Mail applications to the attention of John E. Albers, M.D., Chairman, Committee on Scientific Work, Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215.

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1976 Annual Meeting, Ohio State Medical Association

Cincinnati Convention & Exposition Center, Cincinnati, May 10, 11 and 12

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Auxiliary

MRS. S. L. MELTZER, Communications Chairman

Christmas and AMA-ERF—what a happy combination! A wonderful, meaningful Holiday goes hand in hand with a wonderful, meaningful effort. For some time, the sale of Christmas cards has been a major source of AMA-ERF contributions as has the special "round robin" type of card sent out by county medical societies and their auxiliaries to medical colleagues and their families. The donation is made in the name of a particular medical school or AMA-ERF's General Fund, and that donation gives the doctor and his spouse the privilege of having their name listed on the card. In my own Scioto county, there is 100 percent participation as I'm sure there is in many counties over the state. It is nice to know that in sending Holiday greetings to colleagues, family and friends, these greetings help to make possible gifts to medical schools and help to medical students. What better gift than that which gives continued financial support for medical education and for guaranteeing medical student loans?

Another Santa helper for AMA-ERF is the holly with its bright red berries of warmth and good cheer. The sale of really exceptional holly throughout auxiliaryland is made possible through the endorsement of the Oregon Medical Society Auxiliary so that it is possible to obtain, at special prices, those beautiful berries that "belong" to Christmas. The Brownell Holly Farms in Milwaukie, Oregon, make this additional fund-raising Holiday activity possible.

Of course, AMA-ERF is an all-year-round effort: and it is at the grass roots level that the money is raised by doctors' wives in cooperation with their husbands. The ways in which money is raised each year throughout the year cover a wide variety of activities. There are such business activities (in addition to the Christmas activity already mentioned) as the sale of extraordinary watches and other jewelry, household items of every description,

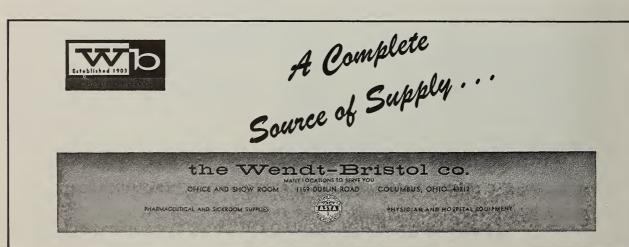
special apparel, souvenir and commemorative plates, stationery, greetings cards for every possible occasion and so on. Then there are the social activities for raising money such as auctions (they have been incredible money makers!), dances, fashion shows, luncheons, bridge parties, teas and theatre parties. There are memorials for loved ones. One thing is for sure. If there is a good way of making money for AMA-ERF, you can be sure the auxiliary is hot on its trail (as is our state chairman, Mrs. Donald Dewald).

LEGISLATION

Mrs. A. N. May and legislation have become almost synonymous! She is that whirlwind of activity who serves as legislation chairman on the state level, a complicated, time-consuming job to put it mildly. (Her legislative bulletins are terrific.) And, of course, legislation is one of the auxiliary's most important activities. It serves two purposes: to keep members informed and up-to-date on legislation health issues facing organized medicine and to involve members in working for good medical legislation by urging and encouraging them to let their voices be heard.

One legislative action project worthy of emphasis is the communication system known as "Legsline." The National Auxiliary designed this vehicle for state and county auxiliaries to assist their medical associations to be heard. It can operate on a letter-writing basis for transmitting up-to-date information implementing any number of public affairs projects or reporting results of completed projects. In the event of an emergency or a need to implement a project immediately, the Legsline system becomes a Legsline Alert to ensure quick and efficient communications.

The structure and procedure are the same for both systems. First, the state legislative chairman is responsible (continued on page 879)



Auxiliary (continued from page 874)

for organizing the Legsline Alert system throughout the state. Second, the county legislative chairman or county president acts as the county Legsline Alert chairman. Third, the county chairman is responsible for selecting at least ten sub-chairmen within the county auxiliary to carry out a telephone alert or letter-writing campaign. Actually there is no real limit on the number of sub-chairmen. The more members who are involved, the more effective the Alert system will be. (Would you believe that when the National Auxiliary was founded back in 1922, and for a number of years after, auxiliary members were forbidden from participating in any legislative activity?? On an auxiliary basis, that is.)

Ingrid May, in a recent legislative bulletin to all county auxiliaries, has this message: "Here is an excellent idea for a joint meeting of your county medical society and your auxiliary. Mr. Charles Edgar, Associate Executive Director and Secretary, Federal Legislative Liaison Committee, OSMA, has informed me that his department has prepared a slide presentation on P.L. 93-641, the Health Planning Law. This presentation deals with the law's impact on health services and facilities in Ohio, particularly the grass roots impact as far as loss of local autonomy is concerned. Should anyone wish this presentation, contact me or Mr. Edgar. Robert E. Holcomb, Field Service Director, has also indicated his staff can assist in planning a program related to the slides."

HERE AND THERE

At its September board meeting, the Hamilton

County Auxiliary voted to make the teaching of breast self-examination to women's groups a new project of the auxiliary. In cooperation with the local chapter of the American Cancer Society, a workshop was held in October at the Academy of Medicine. I'd like to borrow this comment from the group's October auxiliarygram: "This is a golden opportunity for the auxiliary—health education at a basic level. We owe this first of all to ourselves; secondly to our husbands; thirdly, to our families. It is a chance to use in a positive way, our position as physicians' wives for the betterment of the community."

Stark County capsule: There was an October membership meeting at the Massillon Woman's Club. Following the noon luncheon, Mrs. Gertrude Donahey, Treasurer of the State of Ohio, addressed the group. The November 18 meeting was highlighted by a Stern and Manns style show at the Brookside Country Club.

The Scioto County Auxiliary played hostess to the wives of visiting physicians who were attending the October Medical Seminar Weekend sponsored by the Scioto County Medical Society at the Shawnee Park State Lodge. There was a guided tour of historical places and luncheon at Portsmouth's oldest church (founded in the early 1800s)—First Presbyterian.

MERRY CHRISTMAS

I have a favorite anonymous quotation I'd like to pass on to you this Holiday Season:

THINE OWN WISH, WISH WE THEE.



Radiation Therapy Possible Cause of Thyroid Cancer

The AMA and the American Hospital Association are urging OSMA's constituent societies to cooperate in devising plans to meet their communities' needs with respect to thyroid cancer possibly induced by earlier radiation therapy.

In the 1930s, 1940s, and 1950s, it was acceptable medical practice for physicians to prescribe and administer radiation to treat certain problems of the neck and face. For example, radiation was used to shrink children's infected tonsils, adenoids, and thymus glands.

In recent years, however, research studies, such as one by DeGroot and Paloyan appearing in the July 30, 1973, Journal of the American Medical Association, have shown a high correlation between this treatment and cancer. One study by Refetoff et al in the January 23, 1975, New England Journal of Medicine showed a seven percent incidence of thyroid carcinoma in unselected patients

with a history of irradiation to the neck area. This percentage is higher than would be expected in the general population and implies a continuing public health problem.

Although thyroid carcinoma is usually a very slowgrowing cancer that poses little immediate danger to life, there is a need to develop screening procedures and to ensure that persons needing attention receive it..

It is necessary that any community or regional program be carefully planned to make certain that guidelines for screening procedures, treatment, and release of information are developed and agreed upon by all area providers and that other related groups, such as public health departments, are involved in the planning. A coordinated approach can minimize undue public alarm.

Death from thyroid carcinoma is a rare occurrence. The "malignancy" of the thyroid nodules associated with radiation therapy discussed in the available studies was determined by pathologic examination, not by clinical



DESCRIPTION: Methyltestosterone is 178-Hydroxy-17-Methylandrost-4-en-3-one. ACTIONS: Methyltestosterone is an oil soluble androgenic hormone. INDICATIONS: In the male: 1. Eurunchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. PRECAUTIONS: Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. CONTRAINDICATIONS: Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. WARNINGS: If priapism or other signs of excessive sex. au stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or preoccious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. ADVERSE REACTIONS: Cholestatic jaundce • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usua

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course. Therefore, screening is a conservative measure, and the medical communities' response to possible findings also should be appropriately conservative. While surgery may be indicated in some cases, suppressive therapy or regular observation may serve other patients better. The predictable risks of mortality and morbidity from surgery should not be discounted as a community plans to respond to the possible threat of radiation-induced thyroid carcinoma.

There are several possible approaches that can be applied to situations at the community level. One of these is a large scale "call back" in which medical records are searched and each person who received the treatment is contacted. This approach is costly and is hindered by difficulty in locating records and the mobility of the American public.

Another approach is the coordinated use of the

media. This method has been employed in Milwaukee, Wisconsin. The Medical College of Wisconsin, the Milwaukee County Medical Complex, the Wood Veterans Administration Hospital and volunteer physicians have developed a program in conjunction with the media. The screening is free and available to all area residents even though the Milwaukee Medical Center never administered the treatment.

Cincinnati physicians investigated the medical aspects of screening for thyroid cancer, developed specific guidelines for screening and communicated all their findings to the Academy of Medicine, hospital association, and other interested groups before any public announcements were made. Persons seeking screening who did not have a primary physician were referred through the Cincinnati Academy of Medicine to a physician experienced in the diagnosis and treatment of thyroid disease.

Anabolic Stimulant Increased Muscular Tone Osteoporosis

EACH ANDROID-G TABLET CONTAINS:

Ethinyl Estradiol	0.005 mg
Methyltestosterone	1.25 mg
L-lysine	
Nicotinic Acid	
Iron (from Ferrous Sulfate)	
Vitamin A	
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Thiamine Mononitrate	
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Folic Acid	
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Methionine	
Choline Bitartrate	
Inositol	
Calcium Pantothenate	
Pyridoxine	
Copper (from Copper Sulfate)	
Zinc (from Zinc Oxide)	
Iodine (from Potassium Iodide	
Calcium (from Dicalcium Phosphate	
Phosphorus (from Dicalcium Phosphate	
Potassium (from Potassium Sulfate)	
Manganese (from Manganese Sulfate)	
Magnesium (from Magnesium Sulfate)	0.5 mg

ACTION AND USES — DOSAGE: 1 tablet after breakfast and supper, or as required. In females, 3-week courses of therapy are recommended followed by a 1-week rest period. Withdrawal bleeding may occur during the rest period. Withdrawal bleeding may occur during the rest period. PRECAUTIONS: Administer cautiously to female patients who tend to develop excessive hair growth or other signs of masculinization. CONTRAINDICATIONS: Patients in whom estrogen or androgen therapy should not be used, as in carcinoma of the breast, genital tract, or prostate, and in patients with a familial tendency to these types of malignancy. AVAILABLE: Bottles of 100 and 500 tablets.

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Medical Students to Gain Health Care Experience in Appalachia

The Ohio State University College of Medicine will develop a program providing medical students with family health care experience in Ohio's Appalachian region. The curriculum will emphasize health care delivery from the family-oriented rather than the disease-oriented standpoint.

Dr. G. L. Trzebiatowski, Assistant Dean of Medicine and Co-Director of the Family Care Program, said the college would develop the new curriculum, train faculty, and locate cooperating practitioners during the initial year. A pilot group of about ten medical students is expected to enter the program in 1976-1977. Students in the five-month curriculum will spend the first three months training under the program's faculty and the last two months assigned to practitioners in the field.

The five-year project is supported by the U.S. Public Health Service's Regional Health Administration in Chicago.

Marion Pediatrician Wins Award for Scientific Exhibit

At the annual meeting of the American Academy of Pediatrics, the Gold Award was given to Albert N. May, M.D., and Ellen Weaver, P.A., of Marion. The award recognized the scientific exhibit which demonstrated the greatest originality in concept and presentation.

Dr. May's exhibit, "E.P.S.D.T. Screening: A Model Plan at Work in Suburban-Rural Ohio," showed how the EPSDT program was implemented in a five-county area of central Ohio.

Dr. May is chief of pediatrics at the Frederick C. Smith Clinic and at Community Memorial Hospital in Marion. He is also clinical assistant professor of pediatrics and preventive medicine at The Ohio State University College of Medicine.

Operating Procedure Films Authored by Cleveland Surgeons

Three Cleveland surgeons presented films on operating procedures during the 26th Cine Clinic at the Clinical Congress of the American College of Surgeons which met in October. Donald B. Effler, M.D., Senior Surgeon, Department of Thoracic and Cardiovascular Surgery, Cleveland Clinic Foundation, authored a film titled "Aortic Valve Replacement." Robert E. Hermann.

M.D., Head of the Department of General Surgery, and Caldwell B. Esselstyn, Jr., M.D., Department of General Surgery, both of the Cleveland Clinic Foundation, coauthored a film titled "Biliary Stricture-Surgical Management."

These films were developed to replace the wet clinic teaching technique in which a physician learned a new surgical technique by looking over another surgeon's shoulder. Following the showing at the Clinical Congress, the Cine Clinic films were placed in the ACS Film Library to be booked by hospitals, medical associations, and other professional organizations.

The Cine Clinic is sponsored by the American College of Surgeons and Davis and Geck, a department of the Lederle Laboratories Division of American Cyanamid Company.

Grand Rapids M.D. Speaker of Am. Academy of Family Physicians

The Congress of Delegates of the American Academy of Family Physicians (AAFP) re-elected B. Leslie Huffman, Jr., M.D., of Grand Rapids, Ohio, speaker of the Congress. The meeting was held during October in Chicago in conjunction with the AAFP's Annual Scientific Assembly and convention.

The American Academy of Family Physicians is the nation's second largest national medical group. It was a pioneer in mandatory continuing education for members and presently requires a minimum of 150 hours of approved continuing study every three years.

Case Faculty Member Honored By Infectious Diseases Society

Kenneth S. Warren, M.D., a member of the faculty of Case Western Reserve University School of Medicine. received the 1975 Squibb Award of the Infectious Diseases Society of America at the organization's annual meeting. This award is presented annually to a young medical investigator for outstanding accomplishment in the field of infectious diseases. An authority in tropical medicine, Dr. Warren has conducted extensive research dealing with schistosomiasis, a disease affecting approximately 200 million people throughout the world.

Dr. Warren is Professor of Medicine, Director of the Division of Geographic Medicine, Professor of Library Science, and Professor of Community Health at Case. He also serves as physician in charge of parasitology at the Institute of Pathology, Western Reserve University, and as assistant physician at University Hopitals of Cleveland.

Pittsburgh, Pennsylvania

January 16-17, 1976

CARDIORESPIRATORY DISEASES OF COAL WORKERS

CO-SPONSORED BY

The American College of Chest Physicians; the U.S. Department of Health, Education and Welfare, Appalachian Laboratory for Occupational Diseases; the U.S. Department of Labor, Employment Standards Administration.

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COURSE DESCRIPTION

You are cordially invited to attend a two-day symposium whose major goals are:

- To share with you our plans to prepare a physicians handbook on "The Cardiorespiratory Diseases of Coal Workers".
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The meeting will provide a forum for your comments and those of other invited participants.

While there will not be a registration fee for this course, registration will be limited to 50 participants. If you wish to participate we urge you to act now. Complete and return the coupon below or call the American College of Chest Physicians at (312) 698-2200

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THE OHIO STATE MEDICAL JOURNAL

INDEX TO VOLUME 71-1975

January	. Pages	1	to	64	JulyI	Pages	439	to	534
February						,,	535	to	602
March	,,	129	to	208	September	"	603	to	678
April	"	209	to	290	October	"	679	to	750
May	"	291	to	368	November	"	751	to	826
June	"	369	to	438	December	,,	827	to	894

CLINICAL AND SCIENTIFIC PAPERS

Acne (See A New)	Fluoridation (See Effect of Water)					
Adenoidectomy (See Cardiac Arrhythmias During)	Fracture (See Jefferson)					
Adrenocorticosteroid Preparations (See Selection of)	Hypertension (See Primary Pulmonary)					
A Generalist's Approach to Diagnostic Chest X-ray (Henry Bachman) 709	Immunosuppressive Therapy in Rheumatic Diseases. A Retrospective Study					
Amblyopia (See Detection of)	(Marvin H. Thomas; Waldemar Bergen; Vol K. Philips; and Norman O. Rothermich)					
Aneurysmal Bone Cyst of the First Lumbar Pedicle (Edward J. Kosnik; Peter V. Scoles; and Martin P. Sayers)	Influenza (See Disseminated Intravascular Coagulation Associated with)					
A New Acne Cleanser (K. William Kitzmiller)	Instructions to Contributors of Scientific Papers					
Ankle Injuries (See Severe)	Jefferson Fracture of the Atlas. A Case Report (Bruce H. Wolf)					
Appendicitis-Still a Potentially Lethal Disease (John H. Hughes and Roberta	Jejunal Ulceration (See Nonspecific Recurrent)					
G. Kurtz, Med.III)	Lumbar Disc Lesions (See Value of Electromyography)					
Atlas (See Jefferson Fracture of)	Maternal Health in Ohio:					
Autologous Transfusion. Report of a 29-Month Experience in a Large General Hospital (Warren W. Smith and Ms. Patricia Michael)	Choriocarcinoma of the Placenta					
Avascular Necrosis of the Femoral Head in the Adult (Thomas H. Mallory) 548	Maternal Mortality Report for Ohio-1972					
Benign Mixed Tumor of the Lacrimal Gland. A Case Report (James A. Lehman,	Maternal Deaths Following Unattended Delivery					
Jr.; Alfred L. Nicely; and Nadhir Saddawi)	Maternal Deaths Involving Lower Nephron Nephrosis					
Bifid Ureter (See Blind-Ending Branch)	Nonspecific Recurrent Jejunal Ulceration (William P. Skivolocki, Kenneth					
Bile Duct Stones (See Nonsurgical Removal of)	Sirinek, and Thomas Brewer)					
Biopsy-Confirmed Sarcoid Interstitial Fibrosis After a 15-Year Remission (Mark R. Schuyler; Dennis E. Niewoehner; and Jerome I. Kleinerman)	Nonsurgical Removal of Retained Common Bile Duct Stones in Outpatients (Michael Van Aman and William Molnar)					
Blind-Ending Branch of a Bifid Ureter Diagnosed by Intravenous Pyelogram. The Sixth Reported Case (Steven A. Spreen and Arthur T. Evans)	Panencephalitis (See Subacute Sclerosing)					
Bone Cyst (See Aneurysmal)	Platform Shoes (See Severe Ankle Injuries)					
Burn Therapy Program in a Community Hospital (Robert K. Finley, Jr. and	Pressure Pulse Velocity Measurement: An Index of Thyroid Function (Jack Marks)					
Vicki Little, R.N.)	Primary Pulmonary Hypertension and Sickle Cell Trait (Leon Yoder, Enayatollah					
Carcinoembryonic Antigen (CEA): A New Diagnostic Tool (Edward W. Martin, Jr.; William E. Kibbey; and John P. Minton)	Tabeshi, and James T. Taguchi)					
Cardiac Arrhythmias During Tonsillectomy and Adenoidectomy (R. Rodriguez- Torres; A. Lapidot; H. I. Chen; and M. Paydar)	Replantation of Amputated Extremities, Report of Five Cases (Stanley Jaffe;					
Chest X-ray (See A Generalist's Approach)	A. Scott Earle; Earl J. Fleegler; and Elias A. Husni)					
Construction of a Mastery-Oriented Teaching Unit Using a Minicomputer (Steven	Sarcoid Interstitial Fibrosis (See Biopsy-Confirmed)					
J. Mayor, Ph.D.)	Selection of Adrenocorticosteroid Preparations, The (Kenneth Kreines and Irwin					
Cortical Excision as a Supplementary Treatment for Epilepsy (George W. Paulson; Martin P. Sayers; and Robert Calhoun, B.S.)	C. Weinberg)					
Detection of Amblyopia in Young Children (Gary L. Rogers and Morris L. Battles)	Sequel Technique for Localization and Extraction of Radiopaque Foreign Bodies in Various Anatomic Sites (William G. Meyer)					
Disseminated Intravascular Coagulation Associated with Influenza (Harold Settle and Helen I. Glueck)	Severe Ankle Injuries While Wearing Elevated "Platform" Shoes (Ernesto Nieto and Stanley H. Nahigian)					
,	Sickle Cell Trait (See Primary Pulmonary Hypertension and)					
Editor's Note: Policy of AMA Reference Fluoridation of Public Water Supplies	Some Unresolved Questions Regarding Emergency Department Physicians (Oscar P. Hampton, Jr.)					
Effect of Water Fluoridation on Urinary Tract Calculi (Jack L. Summers and	Subacute Sclerosing Panencephalitis (George W. Paulson)					
Walter A. Keitzer)	Thyroid Cancer (See Thyroxine Withdrawal in)					
Electrocardiographic Readings (See Evaluation of Use of Computer-Assist)	Thyroid Function (See Pressure Pulse Velocity Measurement)					
Electromyography in Lumbar Discs (See Value of)	Thyroxine Withdrawal in Thyroid Cancer (George N. Sfakianakis; Thomas G.					
Emergency Department Physicians (See Some Unresolved Questions Regarding)	Skillman; and Jack M. George)					
Epilepsy (See Cortical Excision)	Tonsillectomy (See Cardiac Arrhythmias During)					
Evaluation of the Use of Computer-Assist Electrocardiographic Readings in a 700-Bed General Hospital (Don C. Nouse)	Transfusion (See Autologous) Ulceration, Jejunal (See Nonspecific Recurrent)					
Ex Libris and the Physician (Cecil Striker)	Urologic Screening at Seiberling Grade School in Akron, Ohio. A Pilot Study					
Femoral Head (See Avascular Necrosis of)	(Walter A. Keitzer; James S. Allen; and Jack L. Summers					
Fibrosis (See Biopsy-Confirmed)	Value of Electromyography in Lumbar Disc Lesions (Ian G. MacLean and Paul H. Curtiss, Jr.)					

AUTHORS OF CLINICAL AND SCIENTIFIC PAPERS

Allen, James S. (Akron)	Michael, Patricia (Columbus) 8
Bachman, Henry (McConnelsville)	Minton, John P. (Columbus)
Battles, Morris L. (Columbus) 304	Molnar, William (Columbus)
Bergen, Waldemar (Columbus) 624	Nahigian, Stanley H. (Cleveland)
Brewer, Thomas (Columbus)	Nicely, Alfred L. (Akron)
Calhoun, Robert, B.S. (Columbus)	Nieto, Ernesto (Cleveland)
Chen, Hung I. (Brooklyn, N.Y.)	Niewoehner, Dennis E. (Cleveland)
Curtiss, Paul H., Jr	Nouse, Don C. (Toledo)
Earle, A. Scott (Cleveland)	Paulson, George W. (Columbus)459, 69
Evans, Arthur T. (Cincinnati)	Paydar, Mansureh (Brooklyn, N.Y.)
Finley, Robert K., Jr. (Dayton)	Philips, Vol K. (Columbus)
Fleegler, Earl J. (Cleveland)	Rodriguez-Torres, Ramon (Toledo)
George, Jack M. (Columbus)	Rogers, Gary L. (Columbus)
Glueck, Helen I. (Cincinnati)	Rothermich, Norman O. (Columbus)
Hampton, Oscar P., Jr. (St. Louis, Mo.)	Saddawi, Nadhir (Akron) 30
Hughes, John H. (Toledo)	Sayers, Martin P. (Columbus)459, 84
Husni, Elias A. (Cleveland)	Schuyler, Mark R. (Cleveland)
Jaffe, Stanley (Cleveland) 381	Scoles, Peter V. (Columbus)
Keitzer, Walter A. (Akron)	Settle, Harold (Cincinnati)
Kibbey, William E. (Columbus)	Sfakianakis, George N. (Columbus) 7
Kitzmiller, K. William (Cincinnati)	Sirinek, Kenneth (Columbus) 1
Kleinerman, Jerome I. (Cleveland) 707	Skillman, Thomas G. (Columbus) 7
Kosnik, Edward J. (Lutherville, Md.) 843	Skivolocki, William P. (Columbus)
Kreines, Kenneth (Cincinnati)	Smith, Warren W. (Columbus) 8
Kurtz, Robert G. (Toledo)	Spreen, Steven A. (Cincinnati)
Lapidot, Abraham (Brooklyn, N.Y.)	Striker, Cecil (Cincinnati)
Lehman, James A., Jr. (Akron)	Summers, Jack L. (Akron)
Little, Vicki, R.N. (Dayton)	Tabesh, Enayatollah (Dayton) 7
MacLean, Ian C. (Columbus)	Taguchi, James T. (Dayton)
Mallory, Thomas H. (Columbus) 548	Thomas, Marvin H. (Columbus)
Marks, Jack (Columbus) 544	Van Aman, Michael (Columbus)
Martin, Edward W., Jr. (Columbus) 300	Weinberg, Mr. Irwin C. (Cincinnati)
Mayor, Stephen J., Ph.D. (Toledo)	Wolf, Bruce H. (Canton)
Meyer, William G. (Columbus)	Yoder, Leon (Dayton) 7

GENERAL INDEX

Advertising Classified-63, 127, 206, 288, 361, 435, 531, 599, 675, 747, 748, 823, 892

Advertising Index-62, 126, 206, 288, 360, 433, 530, 598, 676, 746, 822, 891

American Medical Association—
Report of AMA Clinical Convention, 38; AMA Approves Definition of Family Physician, 28; Statement of AMA Before U.S. House of Representatives Sub-Committee on Rural Development, 44; AMA House of Delegates Policy on "Service vs Medical Education," 25; AMA to Launch Regional Continuing Education Program, 84; Pamphlets Available from AMA, 126; AMA Annual Meeting, 180; AMA to Sponsor Conference on Disabled Physicians, 152; Ohio Delegation to AMA Holds Elections, 157; AMA Directory Lists 4,000 Blood Banking Facilities, 183; Adopts Acupuncture Policy, 183; Model Confidentiality Bill Plans to Be Developed, 183; Physicians to Exhibit Art at AMA Annual Meeting, 183; May 16 Is Deadline for AMA Resolutions, 237; AMA Files Suit Against HEW, 237; AMA Conference to Discuss Medical Aspects of Sports, 237; Who Has the Last Word on Judicial Matters? (Two OSMA Members Meet with AMA Council on Constitution and Bylaws), 334; AMA Annual Meeting, June 14-19, 334; Student Association Changes Name to Sever Affiliations with AMA, 292; AMA Taking Economy Measures, 395; AMA Wins Preliminary Injunction Against HEW, 433; AMA Elects New Officers, Raises Membership Dues, 555; Ohio Doctor Is Candidate for AMA President-Elect, 684; HEW Withdraws UR Regs; AMA Drops Its Lawsuit, 684; AMA Clinical Convention to Stress Continuing Education, 692; AMA to Develop Medical Care Programs for Jail Inmates, 693; AMA Membership Hits All-Time High, 757; AMA Past-President Malcolm Todd Speaks Out at Columbus Academy Dinner, 832; Radiation Therapy Possible Cause of Thyroid Cancer, 880

American Medical Association Education and Research Foundation (AMA-ERF)— AMA-ERF Receives Grant for Primary Care Project, 379; AMA-ERF Checks Presented at 1975 Annual Meeting, 492; Your Gift to AMA-ERF Helps Struggling Medical Students, 783

American Medical Political Action Committee-(See Ohio Medical Political Action Committe'

Annual Meeting of OSMA—
Start the New Year Off Right, 48; Hotel Reservations, 50, 107, 135, 284; Scientific Exhibits Wanted, 61; Calendar of Events, 108; Deadline for Submission of Resolutions, 119, 178; Provisions in OSMA Bylaws Concerning Nomination of President-Elect, 99, 175; Scientific Exhibits Application, 115; OMPAC Luncheon, 121, 181, 253; Scientific Programs, 166; Social Night, 182, 254; Special Continuing Education Courses, 249; Additional Scientific Programs, 255; Resolutions, 259; House of Delegates Business Agenda, 263; List of House of Delegates Members, 267; Candidate for OSMA President-Elect, 223; OSMA Headquarters Open House, 271; President's Address, 471; New Officers Elected, 479; Auxiliary Report, 483; Index to Resolutions, 489; Attendance of Delegates, 490; Proceedings of the House of Delegates, 492; Annual Meeting Attendance, 511; Annual Meeting Registration from 1919 to 1975, 512; Scientific Exhibits Wanted, 872

Physicians To Exhibit Art at AMA Annual Convention, 183

Associations, Societies, and Organizations: Regional, National, and International-American Association of Cosmetic Surgeons Has Established a Peer Review Program, 190; American College of Chest Physicians Announce a "Call for Abstracts," 190; Allergists Establish Joint Council of Socio-economics, 189; Gynecologists Meet, 210; Assn. of Physicians of the State of Ohio Hold 1975 Election, 273; Family Practice Board to Give Certification Exam, 282; Need Films for Annual Chest Physicians' Meeting, 292; Ohio Scientists Report on Eve Research Projects, 346; Ohio MD's Named Fellows of American College of Radiology, 347; Defense Dept. Changes CHAMPUS Benefits, 373; American Trauma Society Elects Columbus Physician President, 373; Orthopaedic Society Seeks Entries for Annual Award, 379; Former OSMA President Appointed Chairman of the Comprehensive Health Planning Advisory Council for Ohio, 379; Former Medical Graduates Conference, 395; Natl. Board of Medical Examiners Names Ohio Physician Chairman, 563; Columbus Physician Reelected President of Ohio Heart Assn., 564

Authors of Special Articles and Articles in the Professional Activities Section—Harry Schwartz, Ph.D.: A Half Century of Health Progress, 58; Richard I. Meiling, M.D.: Who Contributes to the Malpractice Crisis? 41; Shirley L. Maccabee, M.L.S., and Susan E. McCarthy, M.L.n: Medline, Do You Know? 199: Manuel Tzagournis, M.D.: The Attack on Oral Diabetes Drugs (guest editorial), 229; James L. Henry, M.D.: A Special Report from Your President—The Professional Liability Crisis, 242; James E. Pohlman, Esq.: A Legal Opinion, 243; Cecil Striker, M.D.: Ex Libris and the Physician, 216; Rebecca J. Doll, Media Relations Editor, OSMA: 'Claims-Made' Policies May Be Insurance Carriers' Reaction to Malpractice Crisis, 316; John B. Chewning, M.D., J.D.: Legal Implications of Generic Drug Substitution, 323; William H. Havener, M.D.: Physicians Play Vital Role in Drug Enforcement Conference, 332; Douglas P. Longenecker, M.D.: Coding Diseases & Problems, 396; How a Bill Becomes a Law (reprinted from The Ohio Banker), 399; Richard L. Meiling, M.D.: A Look at History—Our Medical Heritage, 524; Frank Batley, M.B., Ch.B.: King George III's Insanity - Porphyria: a Royal Malady, 578; R. Gordon Moore: Indian Remedies, 661; Arthur G. King, M.D.: Colonial Medicine in Cincinnati, 722; R. Gordon Moore: Epidemics in Early Ohio, 798; John L. Richmond, M.D.: History of a Successful Case of Cesarean Operation, 868

Bicentennial Series-(See Historian's Notebook)

Comments-(See Editorials and Comments)

Community Health News-(See Ohio Department of Health)

Continuing Medical Education—(See also Medical Education)

Keeping Up: Continuing Medical Education Opportunities for Physicians in Ohio 4; 68; 204; 286; 358; 432; 454; 587; 636; 732; 796; 857 Special Continuing Medical Education Courses at OSMA Annual Meeting, 249; A Community Hospital Revamps Its Continuing Education by Ralph E. Pickett, M.D., 576; AMA Clinical Convention to Stress Continuing Education, 692; New Malpractice Law Requires Proof of Continuing Education, 786; 857

The Council-

Council—Proceedings of October 26-27 Meeting, 29; What the OSMA Council Did at Its December 14-15, 1974 Meeting, 85; Council Approves Policy on Psychologists, 95; OSMA Budget for 1975, 104; What the OSMA Council Did at Its February 1-2 Meeting, 147; Compendium of Medicaid Program, 163; Proceedings of March 8-9 Meeting of The Council 233; OSMA Council Approves Program on the Disabled Physician, 273; Proceedings of April 26-27 Meeting of the Council, 421; OSMA's Council Accepts the Membership and Planning Committee's Recommendation for Another Membership Attitude Survey, 372; New Council Members Elected by 1975 House of Delegates, 479; Proceedings of the House of Delegates 1975 Annual Meeting, 492; Proceedings of the Council Meeting of May 15, 1975, 610; Proceedings of the Council Meeting of May 15, 1975, 610; Proceedings of the Council Meeting of May 15, 1975, 610; Proceedings of the Council Meeting of May 15, 1975, 610; Proceedings of the Council Meeting of May 15, 1975, 610; Proceedings of the Council, September 20-21, 1975, 807

County Medical Societies—
Stark County Elects Officers, 117; Scioto County Gives Scholarships Honoring Dr. Alden B. Oakes, 274; The Academy of Medicine of Toledo and Lucas County File Nomination of Dr. Bates for Candidate of OSMA President-Elect, 223; County Society Roster—Officers and Meeting Dates, 592; AMA Past-President Malcolm Todd Speaks Out at Columbus Academy Dinner, 832; Toledo Hosts Arbitration Forum, 833; Medina County Medical Society Honors State Legislator, 835

Deaths-(See Obituaries)

Disability Determination—(See Social Security)

Distinguished Service Citation-493

Drugs—(See also Pharmaceuticals)
APhA-ASIM Statement on Prescription Writing and Prescription Labeling, 194;
A. H. Robins Refunds Physicians' Unused Stock of Dalkon Shields, 130; Emergency Phone Prescription for Schedule II Drugs, 146; Attack on Oral Diabetes Drugs, 229; Legal Implications of Generic Drug Substitution, 323; Physicians Play Vital Role in Drug Enforcement Conference, 332; FDA Holds Hearings on Oral Antidiabetic Drugs, 563; Narcotic License Renewals Slow, 849

Editorials and Comments—
Richard L. Meiling, M.D.: To Strike or Not to Strike? Is This Really the Question Facing Our Profession? 311: Ohio State Evaluates Independent Study, 311; Foreign Medical Graduates, 395; Physician Salaries, 444; Manual Tzagournis, M.D.: The Attack on Oral Diabetes Drugs, 229; Ohio Society for Prevention of Blindness: Lord, That I Might See, 617; William H. Havener, M.D.: Are We Fair to the Defendant? 717 Robert E. Batterson, M.D.: Good News. Bad News and Old Wives' Tales 717; Trent W. Smith, M.D.: Regional Plastic Surgeons, 763

Environmental and Public Health-(See Ohio Department of Health)

Supreme Court Improves System For Disciplining Ohio Attorneys, 452

Exhibits—(See also Annual Meeting)
Scientific Exhibits Wanted for OSMA Annual Meeting, 61, 872; Scientific Exhibit
Application, 115; "The Outstanding Exhibit, Especially for Educational Matters"
at AMA Clinical Convention Presented by Two Ohio Physicians, 116; OSMA
Awards Doctors for Best Scientific Exhibits, 452; Cleveland Clinic Wins Hektoen
Silver Medal for Original Investigation at AMA Annual Convention, 608

Family Practice—
Family Practice Board to Give Certification Exam Nov. 1-2, 282; Residency Quality: Top Priority, 224; Osteopath School Bill Threat to Family Practice Programs, 372; Two Students Win OSMA's 1975 Family Practice Scholarships, 556; Ohio Family Physicians Elect New Officers, 693; Grand Rapids M.D. Speaker of Am. Academy of Family Physicians, 885

Field Services—
Doug Freeman Joins OSMA's Field Service Department, 347

Financial Report, OSMA and The Journal— Budget for 1975, 104; Report on Examination of Financial Statements for the Year Ended December 31, 1974, 791

Food and Drug Administration—(See Pharmaceuticals)

OSMA Golfers Announce 1975 Tournament Winners, 609

Health—
Alcohol and Mental Health, 349; Cincinnati Appoints Dr. Leff as Health Commissioner, 379; Dr. Robert N. Smith Appointed Chairman of Comprehensive Health Planning Advisory Council, 379; Health Manpower Legislation, 451; 12 Persons Appointed to Ohio Comprehensive Health Planning Advisory Council, 456; Health Revenue Sharing, 444; Glaucoma Screening Involves Legal Responsibilities, 563; Ohio Prison Inmates Receive Only "Crisis" Medical Care, 565; House Passes Health Manpower Act, 572; AMA to Develop Medical Care Programs for Jail Inmates, 693

Historian's Notebook—(and Other Items of Historical Interest)

Ex Libris and the Physician by Cecil Striker, M.D., 216; A Look at History—
Our Medical Heritage, an introductory article for The Journal's Bicentennial Series
by Richard L. Meiling, M.D., 524; King George III's Insanity, Porphyria: A
Royal Malady by Frank Batley, M.B., 578; Indian Remedies by R. Gordon Moore,

661; Colonial Medicine in Cincinnati by Arthur G. King, M.D., 722; Epidemics in Early Ohio by R. Gordon Moore, 798; History of a Successful Case of Cesarean Operation by John L. Richmond, M.D., 868

Hospitals-

pitals—
State Mental Institutions Desperately Need Physicians, 350; OSU Oncology Unit Developed at University Hospitals in Columbus, 349; Two Cleveland Clinic MDs Receive New Posts, 378; State Univ. Hospitals May Be Able to Buy Insurance, 451; A Community Hospital Revamps 1ts Continuing Education, by Ralph E. Pickett, M.D., 577; OSU's University Hospitals to Build 9-Story Patient Tower, 686; Grant Hospital Publishes Infection Control Guide, 756; Course Offered for Hospital Infection Control Personnel, 864

House of Delegates, OSMA—
House of Delegates Business Agenda, 263; List of House of Delegates Members, 267; Resolutions Submitted for Consideration at 1975 Annual Meeting, 259; Attendance of Delegates, 490; Index to Resolutions, 479; President's Address, 471; Proceedings of the House of Delegates 1975 Annual Meeting, 492; Reference Committees Appointed, 493; Plaques and Certificates of Appreciation Presented, 493; Annual Meeting Attendance, 511; OSMA Annual Meeting Registration—1919 to 1975, 512

Immunization—
 Have Your Preschool Patients Been Properly Immunized? 686; It's Not Too Early for Influenza Vaccinations, 692; Good News, Bad News and Old Wives' Tales, 717; Immunization Districts, 865

Who Contributes to the Malpractice Crisis? 41; The Professional Liability Crisis, What Is the OSMA Doing for You? 106; The Professional Liability Crisis, 160; New State Director of Insurance Named, 102; OSMA Group Ordinary Life Insurance Pays Dividend, 178; The Professional Liability Crisis, 8 Special Report from Your President, 242; Teledyne Inc. Announces Plans of Malpractice Insurance, 243; OSMA Group Term Life Insurance Pays Dividend, 274; Physicians Cannot Practice Without Adequate Insurance, 313; National Health Insurance This Year? 314; Tuesdays at The White House, 314; Claims-Made' Policies May Be Insurance Carriers' Reaction to Malpractice Crisis, 316; The Professional Liability Crisis, 319; The State Scene, H.B. 682 Ready for House Debate on June 17, 417; Comprehensive Health Care Insurance Act of 1975 (H.R. 6222), 418; State Univ. Hospitals May Be Able to Buy Insurance, 451; A Giant Step for Ohio Medicine, 650; Shaping a Medical Malpractice Bill, 654; During Its First Month, JUA Gets 823 Applications, 685; Joint Underwriting Assn. Update, 849

The Journal— Jacobson Next OSMJ News Editor, 780

Laws, Legislation, and Court Decisions—
Federal Act Gives Access to Medical Records, 37; Your Stake in Federal Health Manpower Legislation, Health Power Planning, and Resources Development Legislation, 42; National Health Policy, Planning, and Resources Development Act of 1974, 98; Federal Regulations Concerning Sterilization Procedures, 132; Federal Legislative Scene, 158; Summary of the National Health Planning and Resources Development Act of 1974, 238; One License for Common Market, 210; AMA Files Suit Against HEW, 237; Involuntary Servitude for Doctors? 241; University of Toledo Law Review Announces A Colloquium—The Impact of Federal Regulation on the Health Delivery System, 279; Proposed Medical Malpractice Bill in Ohio, 319; Temporary Certificates Not Valid for Practice Outside Hospital or School, 372; Proposed Welfare Billing Systems May Add to Doctors' Paperwork, 378; The 93rd Congress, 395; How a Bill Becomes a Law, 399; The Federal Scene, 418; The State Scene, 417; Health Revenue Sharing, 444; Limiting Medicare Reimbursement, 444; AMA Wins Preliminary Injunction Against HEW, 453; Health Manpower Legislation, 451; The Federal Scene, 572; House Health Manpower Act, 572; S/UR System Monitors Medicaid Expenditures, 572; A Giant Step for Ohio Medicine, 650; Shaping a Malpractice Bill, 654; HEW Withdraws UR Regs; AMA Drops Its Lawsuit, 684; The 111th Ohio General Assembly, 719; New Malpractice Law Requires Proof of Continuing Education, 786; Attorneys to Register with Ohio Supreme Court, 849

Licensure—(See State Medical Board of Ohio)

Malpractice—
Who Contributes to the Malpractice Crisis? 41; The Professional Liability Crisis, 106; 160; 242; 319; Teledyne Inc. Announces Plans of Malpractice Insurance, 243; Physicians Transferring Assets in Light of Malpractice Threat, 243; 'Claims-Made' Policies May be Insurance Carriers' Reaction to Malpractice Crisis, 316; Proposed Medical Malpractice Bill, 319; The State Scene, 417: A Giant Step for Ohio Medicine, 650; Shaping a Medical Malpractice Bill, 654; During Its First Month, JUA Gets 823 Applications, 655; Are We Fair to the Defendant? by William H. Havener, M.D., 717; New Malpractice Law Requires Proof of Continuing Education, 786; Toledo Hosts Arbitration Forum, 833; Joint Underwriting Assn. Update, 849; New Malpractice Law Requires Proof of Continuing Education, 857

Maternal Health-(See Index to Clinical and Scientific Papers)

Or, John A. Bergfeld Appointed Head of Section on Sports Medicine of Cleveland Clinic Dept, of Orthopaedic Surgery, 13; Dr. Lester Ballard, Jr. Named Head of Dept, of Gynecology at the Cleveland Clinic, 60; Dr. Floyd D. Loop and Dr. Samuel Kaplan Participate in Lecture Tour of Latin America, 46; Dr. Ernest W. Johnson to Head Miss Wheelchair America 1975 Contest, 93; Medical Board Elects New Officers, 114; Drs. John M. Tew, Jr. and Frank H. Mayfield Receive Outstanding Exhibit Award at AMA Clinical Convention, 116: Drs. John Ackerman and Timothy Moritz Are Appointed State Directors, 184; James W. Funkhouser, M.D., Named Clinical Professor and Chairman of the Pathology Dept., Wright State University, 338; Dr. David P. Nicholson Appointed Professor of Medicine, and Dr. Nicholas J. Thompson Named Clinical Professor and Chairman of the OB-GYN Dept, Wright State University School of Medicine, 338; Antonio R. Antunez, M.D., Gates Mills: John D. Dunbar, M.D., Columbus; Tearle L. Meyer, M.D., Columbus; and Ollie E. Southard, M.D., Columbus, Named Fellows of American College of Radiology, 347; Dr. Robert E. Herman Elected a Director of American Board of Surgery, 349; Dr. Thomas S. Morse Elected President of American Trauma Society, 373; Dr. Carl E. Wasmuth and Dr. William C. Sheldon

889

Receive New Posts in Cleveland Clinic, 378; Dr. Robert N. Smith Named Chairman of Comprehensive Health Planning Advisory Council in Ohio, 379; Dr. Arnold Leff Appointed Cincinnati Health Commissioner, 379; OSMA Awards Doctors for Best Scientific Exhibits at OSMA Annual Meeting, 452; Frances Harding, M.D., Awarded Honorary Degree, 556; Natl. Board of Medical Examiners Names Ohio Physician Chairman, 563; Dr. Mattmiller Becomes Ohio Usi Vice President, 564; Physician Joins News Team of Cleveland TV Station, 564; OSU Professor Presents Seminars in Great Britain, 564; Ohio Doctors Recognized for Nuclear Medicine Work, 609; New Help for Disabled Physicians, 641; Ohio Doctor (John H. Budd, M.D.) Is Candidate for AMA President-Elect, 684; Akron Doctor Publishes Book on "Practical Psychiatry," 686; Ohio Family Physicians Elect New Officers, 693; Cincinnati Physician (John M. Tew, Jr., M.D.) Elected Officer of Neurological Assn., 756; Esposito Elected President of Amer. Ophthalmology Assn., 780; Canton Physician Edits Ophthalmology Text, 680; Case Faculty Member Honored by Infectious Disease Society, 885; Martio Pediatrician Wins Award for Scientific Exhibit, 885; Operating Procedure Films Authored by Cleveland Surgeons, 885

Medical Advances Institute (MAI)-147, 234, 504, 807

Medical Assistants-

Medical Assistants to Meet, 273; Medical Assistants Inaugurate Akron Woman as Natl. President, 781

Medical Colleges-(See Medical Education)

dical Education—
OSU Study Shows Caring for Patients Isn't Enough, 66; Lipid Research Renewed at University of Cincinnati Medical Center, 120; OSU Trustees OK Plans for New Hospital Facility, 186; Dr. Senhauser to Head OSU Dept. of Pathology, 186: Univ. of Cincinnati Appoints Dean of College of Medicine, 187; Univ. of Cincinnati Names New Medical Center Executive, 187; OSMA Annual Meeting Sponsors 12 Special Continuing Medical Education Courses, 249; OSU Evaluates Independent Study; Finds These Students Score Higher, 311; Apply Now for OSMA's 1975 Family Practice Scholarships, 337; Researchers at Ohio State University Are Developing a Process That Will Help Doctors Pinpoint the Cause of Specific Forms of Balance Disorders, 338; Four Named to Wright State's School of Medicine Faculty, 338; OSU to Establish Medical Dietetics Residency, 338; University of Cincinnati Provides Modern Communications Capabilities to Help Doctor Care for Patients, 343; Case Western Reserve Receives Pharmacology Award, 343; Northern Ohio to Receive Physician Assistant Program, 346; OSU Oncology Unit Developed, 349; Two Students Win OSMA's 1975 Family Practice Scholarships, 556; A Community Hospital Revamps Its Continuing Education, 577; \$670,000 Appropriated for Osteopathic School, 608; OSU's University Hospitals to Build 9-Story Patient Tower, 686; New Malpractice Law Requires Proof of Continuing Education, 786, 857; Course Offered for Hospital Infection Control Personnel, 864; Medical Students to Gain Health Care Experience in Appalachia, 885

Medicare, Medicaid—
Final Regulations for Medicare-Medicaid Review, 28; Early and Periodic Screening, Diagnosis and Treatment of Children Under Title XIX (Medicaid), 163; Limiting Medicare Reimbursement, 444; S/UR System Monitors Medicaid Expenditures, 573; HEW Withdraws UR Regs, AMA Drops Its Lawsuit, 684; Welfare Dept. Completes Survey on EPSDT Program, 692; Report on Implementation of Amended Resolution 7-75, 852

Members, Roster of New OSMA-49, 113, 190, 276, 345, 427, 522, 582, 671, 731, 819,

Miscellaneous-

cellancous—
Judges to Choose 1976 Miss Wheelchair America, 608; Medical Specialists to be Listed in Yellow Pages, 609; For Physicians' Ears Only, Medical News Through Radio, 756; Miss Wheelchair America is Crowned in Columbus, 757; Parents Urged to Discuss Death with Their Children, 781; Thermography Use Defined in Breast Cancer Detection, 849; VA Physician Salaries Augmented, 850; National Education Week on Smoking, 866; Radiation Therapy Possible Cause of Thyroid Cancer, 880; Operating Procedure Films Authored by Cleveland Surgeons, 885

Obituaries—60, 125, 201, 283, 356, 443, 581, 672, 745, 814, 855 In Memoriam: Dr. Edward J. McCormick, 124; Prominent Columbus Physician (Warren G. Harding, II, M.D.) Dies at Age 69, 581

Ohio Department of Health—
Community Health News—Zoster Immune Globulin Program; Tuberculosis Update, 8; Influenza in Ohio—February 1, 1975, 134; Chemoprophylaxis for Contacts of Meningococcal Disease and the Care of Biologicals, 244; Human Rabies Immune Globulin Now Available Around Ohio, 294; Ohio Public Health News, 306; Antihemophilic Factor, 312; Ohio Health News, 413; Treatment Costs for Hemophiliacs Cut, 456; Ohio Public Health Trust Makes First Annual Distribution of Funds, 574; Public Health Rules on Abortion, 633; Ohio Health Service Areas Approved by Federal Gov't., 684; Excerpt from a report made by Dr. Ackerman at 56th Annual Conference of Ohio Health Commissioners on Sept. 10, 1975, 711; Toll Free Line for Reporting Communicable Diseases, 784; Measles Outbreak Containment Program, 784; St. Louis and California Encephalitis, 785; Ohio Dept. of Health Stand on Heimlich Maneuver Supported, 864; Plasmapheresis Center Law Goes into Effect, 864; Immunization Districts, 865; New Hearing Aid Report, 865

Ohio Medical Indemnity— OSMA Named Codefendant in Suit Filed Against OMI, 556

Ohio Medical Political Action Committee (OMPAC)— OMPAC Luncheon, OSMA Annual Meeting, 121; 181; 253; AMPAC Candidates Win, 334

Ohio State Medical Association—(See also Council, House of Delegates, etc.)

The Professional Liability Crisis, 106; OSMA Starts Campaign to Show Medicine Is Doing a Good Job; Rebecca J. Doll Joins the Staff in New Position of Manager of Media Relations, 346; Doug Freeman Joins OSMA's Field Service Dept., 347; OSMA to Conduct Membership Attitude Survey, 372; OSMA Awards Doctors for

Best Scientific Exhibits, 452; Annual Meeting, 471-511; State Association Officers and Committeemen, 589; New Help for Disabled Physicians, 641; OSMA's Executive Director Elected to ASAE Board, 685; Evaluate Your Medical Practice with OSMA's Patient Opinion Poll, 726; Notice to All Members Concerning Dues, 795; State Association Officers, Members of The Council, and Headquarters Staff, 873

Page, Hart F. (Executive Director, OSMA)---OSMA's Executive Director Elected to ASAE Board, 685

Pharmaceuticals, Apparatus, and Related Products—
Pharmaceutical Industry's Research and Development Activities, 116; A. H. Robins Refunds Physicians' Unused Stock of Dalkon Shields, 130; Self-dialysis at VA Centers, 146; Battelle's X-ray Device May Detect Early Breast Cancer, 282; Legal Implications of Generic Drug Substitution, 323; Physicians Play Vital Role in Drug Enforcement Conference, 332; FDA Holds Hearings on Oral Antidiabetic Drugs, 563; Battelle Develops Artificial Muscle, 781

Physicians' Assistants— Northern Ohio to Receive Physician Assistant Program, 346

Postgraduate Activities—(See Continuing Medical Education)

PSROs Awarded \$21 Million in Federal Gov't Grants, 781; Report on Implementation of Amended Resolution 7-75, 852

Public Health—(See Ohio Department of Health)

OSMA Starts Campaign to Show Medicine Is Doing a Good Job, 346; Charles Edgar, Director of Public Relations, Will Devote His Full Time to Internal and External Public Relations; Rebecca J. Doll Is Manager of Media Relations, 346

Research (See also Medical Education) Battelle Develops Artificial Muscle, 781

Resolutions

Nutrons—
Resolutions Submitted for Consideration at 1975 Annual Meeting, 259; Index to Actions on Resolutions, 489; Resolutions Committees Appointed, 493; Report of Committee on Emergency Resolutions, 494; Report of Resolutions Committee No. 1, 495; Report of Resolutions Committee No. 2, 500; Report of Resolutions Committee No. 3, 505

Scholarships—
Scioto Co. Gives Scholarships Honoring Dr. Alden B. Oakes, 274; OSMA Family Practice Scholarships, 337; Two Students Win OSMA's 1975 Family Practice Scholarships, 556

Specialties and Specialty Societies—
American College of Chest Physicians Offers Exam on Chest Disease to Test Your Knowledge, 2; American College of Surgeons Hold 3rd Annual Spring Meeting, April 21-24, 62; Allergists Establish Joint Council of Socio-Economics, 189; Gynecologists Meet, 210; Association of Physicians of State of Ohio Hold Election, 273; Family Practice Board to Give Certification Exam, 282; Ohio MDS Names Fellows of American College of Radiology, 347; American Trauma Society Elects Columbus Physician President, 373; Cincinnati Physician Elected Officer of Neurological Assn. 756; College of Surgeons Announces OB-GYN Manuscript Competition, 780: Esposito Elected President of Amer. Ophthalmology Assn. 780

Sports Medicine—
American College of Sports Medicine Has Planned 22nd Annual Meeting, 13;
Sports Medicine Conference, 178

State Government—
Governor Rhodes Appoints Two Physicians to Direct Departments of Health, Mental Hygiene, 101; New State Directors of Insurance and Welfare, 102; Staff of OSMA's Dept. of Legislation Approached Leadership of Ohio House and Senate Regarding Professional Liability, 160; A Special Report from Your President on Billing in Ohio, 319; The State Scene, 417; Supreme Court Improves System for Disciplining Ohio Attorneys, 452; S/UR System Monitors Medicaid Expenditures, 573; The 111th Ohio General Assembly, 719

State Medical Board of Ohio—
Physicians Licensed in Dec. 1974, 99; New Officers Elected January 8, 1975, 114;
An Inside Look at the State Medical Board, 407; OSMA Concludes Its Interview with William J. Lee, Administrator of Ohio State Medical Board—An Inside Look at the State Medical Board, 516; Medical Board Adopts Position on Hypnosis, 608; Is Your License Valid? 609; State Medical Board Issues Activity Report for 1974, 871

Student AMA— SAMA Commemorates 25th Anniversary, 189; Student Association Changes Name to Sever Affiliations with AMA, New Name of SAMA is American Medical Stu-dent Association (AMSA), 292

South American Adventure Announced, 47; British Isles Adventure, Plus Holland, 171; Adriatic Discovery, 195, 272; Balkan Adventure, 277, 322; Here We Are In Monte Carlo, 420; Mayan Adventure, 606; 710

Woman's Auxiliary— Woman's Auxiliary Highlights—51; 122; 202; 280; 355; 428; 515; 596; 673; 738; 820; 874 Auxiliary Report to OSMA Annual Meeting, 483

Workmen's Compensation— New Billing Procedure Solves Doctors' Bookkeeping Problems, 758









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